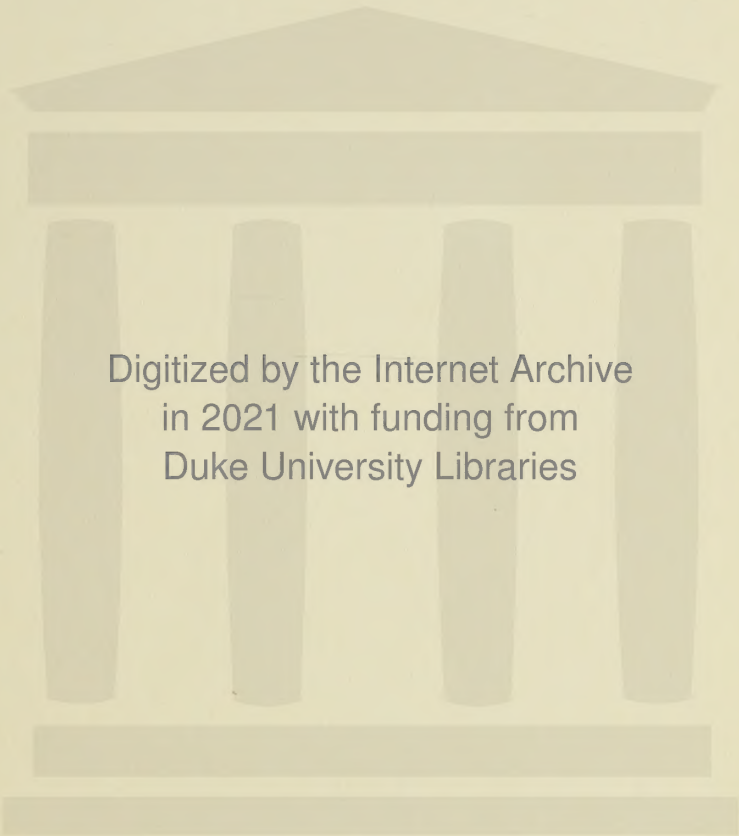

JKE UNIVERSITY PSYCHOLOGICAL MONOGRAPHS · NUMBER 1

THE MANIC-DEPRESSIVE PSYCHOSIS

By HELGE LUNDHOLM, Ph.D.
Associate Professor of Psychology
Duke University

DUKE UNIVERSITY PRESS
Durham, N. C.
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To

MY VENERATED TEACHER AND FRIEND

FREDERIC H. PACKARD

UNDER WHOSE EMINENT DIRECTORSHIP I SPENT NINE HAPPY YEARS AS A MEMBER OF THE STAFF OF McLEAN HOSPITAL, WAVERLEY, MASSACHUSETTS

PREFACE

In January, 1921, I received an appointment at McLean Hospital, Waverley, Massachusetts, not as a physician but as a psychologist. Due to the broad-mindedness of the hospital authorities I had very little routine duties and was allowed to use nearly all my time for independent study of our patients. I wish to express my obligation to the Trustees of McLean Hospital and to its Superintendent for having offered me this generous opportunity.

To the latter, Dr. Frederic H. Packard, to whom I dedicate this monograph, I wish, furthermore, to express my sincere gratitude for the invaluable teaching of psychiatry which he continually and open-handedly kept up, to the great benefit of myself and of my colleagues of the hospital staff, at the innumerable staff-conferences that I attended during nine years,—a teaching in the soundness of which I am profoundly confident.

My first years at McLean Hospital were discouraging. Like the majority of psychologists of my generation I had been trained in the ways of thinking of the sensationist schools. In attempting to apply the sensationist doctrine to the organization of the material which had fallen to my lot, I repeatedly hit an impenetrable wall. Like so many psychologists who have entered the applied field, I found little possibility of progress along the current mechanistic line of approach. However, I soon became acquainted with Professor William McDougall, whose doctrine of "hormic" psychology interested me intensely. It interested me in general because it seemed to offer a scientific system that helped me to understand my own mental life, but it interested me in particular because it seemed to me that Professor McDougall had himself applied his doctrine with remarkable success to the problems of abnormal psychology. The conviction that I had here found a fruitful theoretical basis of my work stimulated me to a renewed attack along this line and I found relief from the sense of futility that hitherto had oppressed me.

I wish to express my deep indebtedness to Professor McDougall for having led me to this new point of view which has made it possible for me to proceed with happiness and some profit in my studies of the mentally deranged human mind.

My interest naturally came to center round the problems of the two great "functional" psychoses, the manic-depressive disorder and schizophrenia. I submit in this work the results of my endeavour to organize the clinical facts of the former disease under an explanatory hypothesis and I hope that this study may be followed by another concerning schizophrenia. I am particularly eager in this aspiration; for the comparison of the two disorders in their psychological aspects will bring into strong relief their essential characteristics and their fundamental differences. While the manic-depressive psychosis is to my mind an acute disorder which may set in at any time of life in individuals of a certain mental constitution, and from which recovery is the rule rather than the exception, the schizophrenic disorder is mostly a chronic aberration of personality, consisting in a going astray, from the very beginning of life, from normal healthy character-formation, a perversion of mental growth which is also constitutionally determined and which may blossom into an explicit disease-syndrome, whenever, before the age of about forty, an individual is confronted with some more serious problem of adjustment, such as the problem of puberty, the religious problem, or the problem of adaptation to marital life.

I beg all my friends and former colleagues on the staff of McLean Hospital to accept my hearty thanks. On hundreds of occasions, I have found them willing to discuss with me the problems and principles laid down in this monograph and I admit gratefully that without these discussions the principles would never have been evolved.

I also wish to express my thanks to Duke University whose Press has undertaken the publication of this monograph, which, it is hoped, is but the first number of a series.

HELGE LUNDHOLM.

Durham, Dec. 13, 1930.

FOREWORD

A work of pure literature by a promising young author may fittingly be introduced to the public by a few words of discriminating praise from an older writer whose work is more widely known. A scientific monograph should need no introduction from any other pen than its author's. My few words here may, then, seem unwarranted; they may seem even to throw doubt on the scientific merit of Dr. Lundholm's short treatise. If psychology and its ally, psychiatry, were in a satisfactory condition, if we had in these fields some solid nucleus of generally accepted fact and theory, no suggestion of any introductory words from me would have arisen. But these allied sciences, in spite of widespread popular interest in them, are in anything but a satisfactory condition. Both alike are the battle ground of warring sects that have little in common, each using a terminology and a way of thinking peculiar to itself. The resulting confusion in these fields is due to no innate depravity of the contestants but rather to their intrinsic difficulties. The war therefore must go on; and if we fight as honest men, respecting our opponents while attacking their views, the truth will in the end prevail. Hence, when one finds an adherent of one's own sect struggling manfully to promote its doctrines, one is justified in lending a hand in any way that may seem to promote the common interest. And I feel that I may do this in some slight degree by pointing out here a fact which Dr. Lundholm could not well proclaim, the fact, namely, that Dr. Lundholm holds a position which, so far as my knowledge of the field goes, seems to be unique. He is neither a psychiatrist nor a psychoanalyst, but what for the purpose of promoting our knowledge of the human mind and its disorders is far better, namely a well-trained and open-minded psychologist who for many years has devoted himself to pure research among the patients of a large mental hospital. Moreover, he is not a psychologist of the type only too common among us, the type that dogmatically takes its

stand upon the mechanistic materialism of nineteenth century science, and confidently, blindly, assumes that all the problems of human nature are in principle already solved by a mechanical reflexology. Rather he is a psychologist who recognizes that the human soul still has its mysteries, that the nature of life and of mind and their relation to matter and the physical world are still open questions on which all our efforts have as yet thrown but little light, questions in face of which the psychologist, above all men, needs to maintain an open, a humble, and an enquiring mind, an insatiable and alert curiosity, a faith in the methods of science without belief in the ultimate validity of any of its present-day conclusions. For in science, as contemporary physics so clearly teaches us, there are no conclusions, rather only new beginnings, new quests, wider horizons "whose margins fade forever and forever from our sight." This does not mean that Dr. Lundholm leaves unused such knowledge as physics and chemistry and physiology put at our disposal. He is eager to make full use of such knowledge, as shown by his interesting speculation in this monograph on the bodily basis of his "imperial moods," and on the chemical factor in the genesis of manic-depressive insanity. While Dr. Lundholm rejects the prevalent mechanistic dogmas, he equally avoids the intellectualistic error that has long been the other great bane of psychology, the error that man's mind is intellect alone, a system of sensations or ideas or merely cognitive capacities. He believes that all our intellectual structure is built upon a foundation of deepseated biological urges which, while making themselves felt but obscurely or not at all in consciousness, impel us powerfully towards goals conceived, for the most part, but vaguely and inadequately; and he believes that the essential grounds of the great functional disorders of mind are to be sought in failure of these fundamental impulses to coöperate harmoniously in the way which is of the essence of healthy personality. That is to say that Dr. Lundholm belongs unequivocally to the school of thought which is now coming to be known as the hormic school of psychology. This school is

no new one; it is as old as Aristotle; but for long ages it has been smothered beneath the errors of intellectualism and, in the modern period, by the mistaken ambition to mould biology and psychology after the model of the physical sciences. The resurrection of this school of thinking seems to him, as to many others, to promise to bring at last steady and rapid progress in psychology and psychiatry and a growing consensus of opinion and effective coöperation among the workers in both fields.

Whatever then be the fate in store for the hypotheses so interestingly propounded in the pages of this monograph, I have no reserve in proclaiming his work as of a type most urgently needed and in expressing the hope that workers of his stamp, the pure research psychologist in the psychiatric field, may be rapidly multiplied. The psychiatrist busy with his practice, preoccupied with the disposal and care of his patients, is only in the rarest cases a psychologist, and even then can hardly find time for intimate study of his cases. The field of mental disorder offers the richest finds to the psychologist, and without psychology psychiatry must remain relatively barren.

WILLIAM MCDOUGALL

CONTENTS

CHAPTER I

Formulation of the Problem and Outline of the Survey

The theory concerning the manic-depressive psychosis that I am going to propound in this monograph is, in its general aspect, neither new nor mine. Its essential feature, namely, that this disorder has a toxic basis, has been intuitively acknowledged by a large number of psychiatrists in spite of the fact that no chemist has yet been able to determine the crucial poison. In view of the frequent occurrence in the case records of manic-depressive patients, of a history of overwork or other forms of excessive mental strain in a period immediately preceding the disorder, many psychiatrists hold explicitly that the poison is some kind of fatigue-product of metabolism. In consideration of the fact that the reaction type of the manic-depressive psychosis not infrequently appears also in toxic conditions of demonstrably other origin, as, for instance, in the case of alcoholic toxemia, or in the case of various states following the over-use of sedatives, veronal, bromides, and what not, it may be wiser not to be too specific as to the nature of the toxin. This much, however, may be justly assumed, that the toxin promoting a manic-depressive reaction is of the general nature of the depressant drug.

The theory, as formulated in such terms, does not exclude that a fatigue product of metabolism may be, originally, the toxic agent of the disorder, either alone or in conjunction with some other chemical; neither does it exclude the possibility that, during the vicious course of the disease, a fatigue poison may add its effect to the original toxic influences. The latter, indeed, merits belief, since many patients, urged by a frantic drive, exert such monstruously intensive activity that fatigue unavoidably must result; and because, in order to explain a number of other symptoms of the disease, we have to refer necessarily to the second component of fatigue, namely, the lasting exhaustion of the effector system of the body, an ex-

haustion which lowers and sometimes nearly extinguishes the functional capacity of the latter. The two-component view of fatigue referred to here may not be sufficiently substantiated. Particularly may some doubt be attached to the importance of the toxic factor. Be that as it may, if a fatigue poison participates in the production of manic-depressive symptoms, its function, like the function of any depressant drug, is essentially to disturb the proper integrative distribution of psycho-physical energies, while the exhaustive component of fatigue refers to the reduction in capacity of the effector system to transform and generate psycho-physical energies.

As long as the bio-chemical work on the manic-depressive patients has not revealed the causative toxin of their disease and as long as a possible effect of a possible toxin on their nervous system has not been observed under the microscope, the theory will retain the earmarks of a hypothesis or a sheer speculation. Yet psychological considerations may be brought to bear on it in some measure. If, under certain broad assumptions which concern, on the one hand, general psycho-physical interrelations and, on the other, the general effect of the depressant drugs on the nervous system, it can be demonstrated that a large variety of the major symptoms of the psychosis are reasonably interpretable as the psychological reflection of the effect of the latter type of drug, this will indirectly support the toxic theory, in spite of the hitherto negative chemical evidence of the presence of the drug. I shall endeavour to undertake such demonstration in this thesis and I proceed immediately with formulating the basic premises.

However hesitatingly we may express a definite opinion about psychoneural interrelations in view of the insufficient knowledge of both the topography and function of neural structure, such assumption as the following will probably not be too bold: The gradual acquisition, during mental growth, of adaptive integration of our cognitive-conative propensities into personality is probably concomitant, on the physical

plane, to the gradual acquisition of integrative communication between neurones and neurone systems on the higher level of the nervous system, especially on the cortical. This is the first premise for the coming discourse. The second, which we may formulate also without being too overspecific, is as follows: The influence of a depressant drug on the nervous system is essentially to disturb or derange, in a general way, this neural integration of the higher brain-level, so as to produce, psychologically, exactly the state of general disintegration of personality.

Writers, like Prof. William McDougall, have spoken of this effect of the depressant drug on the nervous system as a "general dissociation of the brain," and this choice of term has been determined by the hypothesis that the drug attacks the neural matter at synaptic junctions. It is assumed to produce in these an increase in resistance towards nervous flow, and thus a kind of relative falling apart or isolation of neurone systems which, in its turn, deranges their proficient integrative function. Recent evidence from the physiological laboratory, particularly the work of Lashley, has tended to throw some doubt upon the validity of such synapse theory, and although in the following I shall adopt the term "general dissociation of the brain" as a denomination of the toxic effect in question, I wish to emphasize my reservation as to its specific nature.

The two premises above, on the one hand, that the growth of mental integration into personality and the growth of neural integration on the higher brain-level are two aspects of one and the same development, and on the other hand, that the effect of the depressant drug on the nervous system is essentially to derange generally this neural integration, we assume to be valid in their general formulation. If this is correct, the truth of the toxic theory of the manic-depressive psychosis will be indirectly supported in proportion to the measure in which we can show that the majority of its observable manifestations are exactly of the kind that would be expected if all the effects of adaptive integration tempo-

rarily disappeared. We must keep in mind that, although general disintegration of mind may be also the result of cortical atrophy or of structural devastation of the cortex by a germ, these possibilities are excluded from the manic-depressive disorder by the fact that the disease is only temporary and that full recovery from it is the rule. Consequently, if its symptoms in the analysis should turn out to be essentially disintegrative, the nearest explanatory reference remaining would be the reference to a toxemia. The evaluation of the symptoms, and the determination of their relation to a disintegrative process, has to be based on an intimate appreciation of the effects which, in the ontogenetic mental growth of man, the adaptive integration aims at and accomplishes.

The last paragraph formulates the problem of my thesis: to investigate the interpretability of the manic-depressive symptoms as ramifications of general disintegration of personality. As this investigation, which will be carried out entirely in the psychological realm, during its progress will bring us in contact with a vast material of facts, principles, and theories, intricately interrelated and depending upon each other, it may be profitable for the clarity of my presentation to offer a general outline of the course of the survey.

The discussion will fall into three parts, which will be followed by a general summary in the form of a diagram, and by a short paragraph on the theoretical conclusions of the investigation.

Part I, which is intended to prepare for the analysis of the manic-depressive symptoms, lays down the essential aims and effects of the normal adaptive integration of mind into personality, and discusses the two principles or processes involved in the ontogenetic growth of adaptive integration, namely, the processes of sublimation and repression.

Part II deals with the manic-depressive symptoms which are directly understandable as the result of a process of temporary general disintegration of personality. It also deals with a number of reactions which are accessory to or superimposed upon these directly disintegrative symptoms. The

disintegrative symptoms fall into three syndromes, corresponding to three levels of profundity of disintegration and also to three stages of depth of psychosis.

Part III deals with the three "imperial moods" of the manic-depressive psychosis, the feeling of omnipotency, the feeling of inadequacy, and the feeling of unreality. The two first of these cannot be explained merely as the result of a disintegrative process, but have to be referred to a constitutional trait of the patient, the cycloid trait. The intensification of these moods in the psychotic state, on the other hand, can only be understood by a reference to the disintegrative process. The third of the "imperial moods" can be directly explained by a disintegrative process. Part III also deals with a number of reaction-forms which are either the product of the moods themselves or the product of the joint effect of the moods and the reaction-tendencies which are directly determined by the disintegrative process.

CHAPTER II

The Adaptive Integration of Mind By the Processes of Sublimation and Repression

Adaptation, in the human being, is in its most important aspect adaptation to the imperative necessity of group-life. The gregarious instinct, the potential of our desire to live in hordes, does not in itself lead us to adaptation. It is primarily egotistic in its goal and urges man and animal to join the group for the sake of their own protection. True adaptation can only take place by virtue of a sentiment in which the gregarious impulse enters into conjunction with the protective. Only through such sentiment can the group be appreciated as a value higher than the self, and as an object, the welfare of which is even more important than the welfare of the self. Only through such sentiment will the group be looked upon as something that should be protected and promoted even at the expense of the self. And promotion of the group at the expense of the self means, in one of its phases, inhibition of egotistic urges for the sake of altruistic group-furthering ideals, which in its turn is one of the essentials of adaptation.

The adaptive integration of human mind is a process of mental growth; it is a matter of development of adaptive habits by continual exercising of adaptive conduct. It is a gradual process beginning in early childhood and lasting unto the very climax of manhood and womanhood. In accordance with the claim of the previous paragraph it is, in one of its aspects, a process of acquisition of habitual inhibitions, one phase of adaptive conduct being inhibition. The habitual inhibition concerns the crude egotistic manifestations of primitive instinctive drives. There are two principles determining the growth of adaptive integration. The ideal principle as far as proficiency goes is called sublimation. A less proficient principle which aims at adaptive integration but which reaches its goal only with partial success is the process called repression. Both sublimation and repression are in essential part processes

of inhibition. Neither of them can be even remotely understood except by a theory of inhibition by drainage, such as has been suggested and is maintained by Prof. McDougall.

Sublimation may be defined as the substitution of the goals of the crude egotistic instinctive strivings by increasingly higher social, moral, or altruistic goals. Or, as Prof. McDougall expresses the matter, "The essence of sublimation, broadly conceived, is the raising of the moral plane upon which the energies of our native tendencies are expended. . . ." (Bibliographical Reference 8, p. 134.) Such substitution involves the inhibition of the crude drives by a drainage of their energy into social, ethical, and altruistic channels, a drainage by which the instinctive energies come to be utilized and manifested in constructive social activity. The integration of the social sentiments under a dominating altruistic ideal is merely the highest attainment of proficient habitual sublimation. It is the adaptive integration par excellence and represents the only profoundly sound personality growth.

Any application of a theory of drainage to the problems of inhibition presupposes that the draining impulse possesses a primary energy of its own in addition to which it assimilates and utilizes for its purposes the energies of the drained impulse. The primary energy of any sublimating sentiment I have claimed to originate ultimately in the protective instinctive drive or, in other instances, it may be the effect of a joint generation from the protective instinct and the submissive. To clarify this point I permit myself to re-state briefly the description of the socialization of the child which I have submitted in a previous paper (Bib. ref. 3). The growth of altruistic character in the child and the adolescent takes place "stepwise" and is induced by the suggestion from the side of parents and teachers of increasingly higher altruistic goals to be followed. But the acceptance by the child of the higher goals is not merely an intellectual process, it is also affective. The goal suggested by the parent has no meaning to the child until it has become associated with some source of energy by which association it can generate an impulse to

activity and particularly to corrective activity relative to the crude drive. This is in concordance with one of the most important principles in psychology, namely, that meaning is determined by striving. Such association has consequently to be built up by the parent along with the presentation of the higher goal as an alternative. In telling the child about the desirability of doing so and so, instead of giving vent to the primitive drive, the parent has to appeal to and evoke his protective impulse, make clear to him that the crude act will cause distress to others, will hurt others, and so forth. This, only, will give real meaning to the new goal, a meaning that is determined by the evocation of the child's tender impulse. Such method of socialization can naturally be used first when the child has reached an age when he is capable of appreciating his social environment. Previous to this the socialization of the crude tendencies may proceed by evoking the submissive impulse which is capable of being brought into activity by objects far less differentiated cognitively than those releasing the protective impulse. The old-fashioned method of scaring the child to make him behave is dangerously liable to failure in the long run, and the failure of such procedure in the establishment of true social character lies in the fact that, here, appeal is made to one egotistic drive, the instinct of escape, in order to correct another. The same danger threatens when, appealing to the acquisitive instinctive tendency, you make the child behave merely because of the reward he is expecting. Sublimation on any level of development follows in general the simple formula I have laid down for the socialization of the child; or, in other words, what I have spoken of here as the socialization of the child is really the earliest form of sublimation. This may be enough to clarify my assertion that the primary energy of any sublimating sentiment is ultimately drawn from the protective or tender instinctive impulse.

It is important to notice that, on each stage of development, before sublimation has become a habitual process, the act of sublimation may be in strong conflict with a lower

striving, and that, at such state of affairs, each instance of successful sublimation may be looked upon as a conflict-solution, a solution of a battle between a crude impulse and the substitutive higher alternative one. Such conflict may occur on any stage of individual development. It is not confined merely to childhood or early adolescence. Even the highest ideals of manhood may have a period subsequent to their conception, when they are in conflict with less sublime impulses, and when the final assimilation of the energy of the latter succeeds first after severe conflict. (Example: Christ's conflict in the garden of Gethsemane.) Each successful sublimation, however, strengthens the sublimating impulse and in strong and healthy character, the ideal result of adaptive integration, the altruistic master-sentiment performs easily and smoothly the inhibitions of lower desires which are necessary for its purposes.

It is also important to notice that, although sublimation assimilates with the primary energies of the sublimating impulse the forces of the crude instinctive drives, utilizing these forces in high, constructive, and ethical activities, this is not equivalent to a complete eradication of natural instinctive expression. The maintenance of both the individual and the race requires some working of our instincts along their natural routes; but for the allowance of the food-seeking impulse, the sex impulse, the acquisitive impulse, and so on, humanity would vanish shortly. Sublimation does not kill the natural impulses, but it brings them under control of the higher ones; it introduces, for instance, proper deliberation in the admission of their natural manifestations and it even refines their natural expression, subdues it in the sense of depriving it of its cruel animal beastliness. Thus, in western civilized people, the working of the socialized sex-instinct is deprived of its sadistic component, which oftentimes is openly displayed on the animal plane, and which is obvious in the love-life of many primitive people, while in others it has undergone a primal form of sublimation in the ritualistic violent abduction and rape of the bride. The effect of sublimation on the working

of the natural impulses can be brought into relief if we consider the following. The crude, instinctive reactions, as seen in animals and in non-civilized people, are all tantrums. This means that they assert themselves in their fullest intensity immediately upon the evocation of the desire by the presence of the proper exciting object. As Prof. McDougall writes concerning the primitive man: "In all things he will be passionate and unrestrained; so that, as in the famous instance described by a traveller . . . he may, though a tender father, in a moment of violent anger seize his child by the ankles, dash out its brain against a rock, and then nurse its corpse in genuine grief. . . ." (Bib. ref. 8, p. 134.) Sublimation modifies the crude instinctive reactions from tantrum responses into controlled outlets of desire, partly by introducing proper deliberation in their allowance and partly by dismantling them of their crude, inconsiderate violence.

There is little doubt in my mind that individuals differ in capacity to sublimate. In fact, there are few individual differences of character that stand out to the un-prejudiced observer of his fellowmen as clearly as the difference in this trait or potentiality. In view of the fact that negative capacity to sublimate so frequently seems to reflect itself all through the life of certain individuals, while, on the other hand, others seem to be able to accomplish easily the inhibitions necessary for social adaptation from the very beginning of their display of social conduct, I have assumed that the positive and negative capacity of sublimation has a constitutional basis, and I believe it proper to refer them to the two constitutional traits which, in several previous articles, I have discussed as the A- and E-tendencies.

The theory of constitutional A- and E-tendencies, or tendencies to develop altruistic sentiments on one hand and egotism on the other, I presented for the first time in 1926 (Bib. ref. 2). Since then the concept of these tendencies has undergone certain modifications in my own mind, in that I have come to consider them as true traits of "disposition" in the sense Prof. McDougall gives the term disposition, when he

uses it with its narrower connotation. "A man's disposition," writes McDougall, "is the sum total of his instinctive tendencies. It is possible that in some individuals one or more of the instincts may be wholly lacking, as seems to be the case in some domesticated animals. But, apart from that possibility, it seems clear that individuals inherit the instinctive impulses in very different degrees of strength. Thus there are men and races in which the instinct of curiosity seems to be innately feeble, others in which it is innately strong. The same seems to be true of other instinctive impulses, notably sex, fear, anger, self-assertion, and submission, and the gregarious impulse . . ." (Bib. ref. 6, p. 351). Lining up the general character of altruistic and egotistic conduct with this concept of disposition, I have come to feel that the constitutional predeterminants of inclinations in one or the other direction, towards altruism or egotism, may be properly considered to be dispositions of the following types: corresponding to the A-tendency, a disposition in which by birth the protective tendency is strong and in which a submissive tendency properly balances the assertiveness; corresponding to the E-tendency, a disposition in which by birth the protective instinct is weak or absent, and the submissive tendency also of undue weakness. In accordance with this concept of the two tendencies I now call them A- and E-dispositions.

This modification of the interpretation of the concepts was foreshadowed in my paper on Confusion published in 1929 (Bib. ref. 3); it was also definitely stated in a separate paper read at the International Psychological Congress in New Haven on September of the same year (Bib. ref. 4).

The reference of positive and negative capacity to sublimate to the A- and E-disposition seems proper if we review what I have brought out earlier in this paper concerning the healthy growth of personality integration. I have endeavoured to show that a sublimating sentiment always derives its primary energy ultimately from the protective instinctive impulse or from the protective and the submissive in conjunction. This would mean that proficient sublimation would be conditioned

by a disposition in which these two impulses were strong by birth. On the other hand, it would mean that incapacity to sublimate may have its root in a constitutional deficiency of these two instincts, or in a disposition in which these were weak or absent by birth. It is merely to state such a situation in other words when we say that the positive capacity to sublimate is constitutionally determined by the A-disposition and the negative capacity to sublimate is determined by the E-disposition, these two terms being adequate to the two kinds of dispositions described.

Let us now consider those individuals whom we have hypothetically claimed to be born with E-disposition, in other words, the born egotists. We have to acknowledge properly that even egotistic individuals are capable of a certain measure of adaptive adjustment to the codes of conduct of their group. Such adjustment implies the existence of some measure of control of the crude egotistic drives, some measure of inhibition for the benefit of the social institution, in short, some measure of adaptive integration of personality. The growth of personality integration in the born egotist is, however, promoted by vastly different processes than the ones involved in the integration of mind under altruistic master-sentiments. The egotist cannot sublimate, for the simple reason that he cannot acquire altruistic sentiments, sufficient primary energy not being derivable for such sentiments because of the constitutional weakness or absence of the protective instinctive impulse. The process involved in the integration of his mind is instead, I suggest, essentially the process of repression.

Repression like sublimation is a mode of dealing with conflict; repression like sublimation involves inhibition. But, while in sublimation the inhibiting agent is a dominating altruistic master-sentiment, deriving its primary energy from the protective instinctive drive and draining the energies of the conflicting impulse into socially purposeful goals which promote the maintenance of moral ideals, the inhibiting agent in repression is, in most instances, an egotistic fear of social

disapproval, of painful friction with one's fellow-beings. In other instances it may be such fear in conjunction with a purely egotistic desire for approval. In repression there is no wholehearted appreciation of the value of the social conduct per se, as promoting the welfare of the multitude; there is no joy in the constructiveness of the socialized conduct-form in itself, because such value and such joy would only have meaning if carried primarily by the protective impulse; instead there is, deep in the heart, a nagging grief at the necessity of checking too abundant egotistic conduct, even if the fear of disapproval or the egotistic desire for social approval is dominant enough to accomplish the inhibition. The conflict is thus never fully solved by repression. The overt expression of the conflicting impulse may be controlled, but the desire may remain in consciousness and conflict on the imaginative plane with the adjustive sentiment, whatever the latter may be. As repression becomes habitual, the conflict may be eliminated entirely from consciousness, but even under such condition it may continue on the subconscious level and wear on the strength of the individual, sometimes to a degree so as to produce exhaustion-disorder. There is abundant evidence for the existence of such subconscious conflict in the material brought forth by the mental exploration of the subconscious mind of the psychoneurotics. To summarize, we may say that, while repression aims at adaptive integration, by its inefficient *modus operandi* even when habitual, it really produces a splitting of personality. It succeeds superficially to integrate adaptively the visible, overtly acting individual, but, in so doing, it establishes a second subconscious personality part. All the egotistic wishes which by habitual repression have been deprived of conscious recognition form an autochthonous cosmos which, by virtue of its own dominant, may become integrated into a subconscious character. This subconscious personality-part, accumulating continually the crude egotistic desires, may continue to conflict, on the subconscious plane, with the nuclear self, while the latter or the personality-part which expresses itself overtly and socially, superficially seen

may present a fair measure of adaptiveness. We may assume that, in contrast to repression, the process of sublimation, by virtue of its higher efficiency as an inhibitory process, produces a successful adaptive integration of the total personality under one dominating master-sentiment, so that, when the process has become a strongly established habit, this sentiment has under its control, not merely the temporarily conscious and overtly active self, but also all the extra-conscious potentialities which may become activated and strive to assert themselves either consciously or subconsciously.

I hardly need to say that the perfectly healthy integration of mind, which would result from a growth of personality in which only the process of sublimation has been involved, is an abstract ideal, just as the opposite growth of integration involving only repression is an abstraction. The average normal man and woman probably both repress and sublimate, with a preponderance, however, of the process of sublimation. The relative involvement of the two processes in the individual growth of mind I maintain to be probably constitutionally determined by the prevalence of A- or E-disposition.

The discussion of sublimation and repression which I have submitted here may seem rather speculative. It should be kept in mind, however, that the two concepts are hypothetical and that their only criterion of validity and realness is the pragmatic one of their usefulness in the explanation and organization of human experience. Such being the case, we must, in formulating the concepts, strive to define their nature in such terms as to give them the maximum measure of utility value. This I have endeavored to do in my previous discussion, and I believe that the two principles of sublimation and repression, understood accordingly, form an important link in the structure of basic presumptions on which systematic normal and abnormal psychology is founded.

CHAPTER III

Manic-Depressive Symptoms Directly Referable to a General Disintegrative Process

Knowing now, in general, about the nature and aim of adaptive integration as promoted, in its ideal form, by the process of sublimation and, in its inferior form, by the process of repression, we may proceed to the survey of the more typical symptoms of the manic-depressive disorder. As we shall see, such survey reveals that the majority of the disease symptoms can be understood as an undoing of the very effects that adaptive integration aimed at and endeavoured to establish more or less successfully in the mental growth of the individual. More specifically the survey reveals that a large number of the major symptoms can be grouped in three categories, depending upon the profundity of general disintegration, or upon the degree of general breaking down of adaptive inhibition by which they are determined. The categories can be rubricated as follows:

1. A group of symptoms which represent the breaking down of the very weakest adaptive inhibitions, those which, during the growth of integration, have been established essentially by the process of repression. These symptoms we may call manifestations on the first level of profundity of disintegration.
2. A group of symptoms which represent the breaking down of more profoundly moulded adaptive inhibitions, resulting chiefly in a liability for tantrum emotional reactions. Superimposed on this condition occur a multitude of judgment-defects and delusions determined by the preponderance of affective as compared with rational thinking, which is the natural consequence of the supremacy of the emotion in the tantrum response. These symptoms we may call manifestations on the second level of profundity of disintegration.

3. A group of symptoms representing the breaking down of even the most profound adaptive inhibitions, resulting, so to speak, in the return of cosmos to chaos when disparate impulses, simultaneously activated, continually conflict with and deadlock each other in a non-purposeful manner, bringing about blocking and distortion of adaptive conduct. This condition is essentially what the psychiatrists call "confusion," and its symptoms may be spoken of as manifestations on the third level of profundity of disintegration.

As the three symptom groups, in the order given, represent psychologically an increase in profundity of a disintegrative process, they also represent medically an increase in sickness of the patient. In illustrating the different symptoms of the groups, we can adopt, consequently, the method of following the progress of the psychosis from its onset to its climax.

The manic-depressive psychosis may begin either with a mild general feeling of increased potency or with a mild general feeling of inadequacy. What agent selects and determines these initial moods is not known, but I shall suggest later a tentative hypothesis concerning this most difficult problem of the disorder.

Whether the onset is colored by the positive or the negative feeling of potency, it is characterized by one common feature, namely, a gradually increasing egotism of the patient, a trait which expresses itself in an inclination to over-consider and over-evaluate the self and everything referred to it. This inclination has its negative reflection in an increasing tendency to disconsider the opinions and feelings of others. It is true that in the hyper-potent or hypomanic phase, a patient often manifests interest also in the outside world, its situations and people, but this only so far as these are objects to be imposed upon by himself. Thus a woman patient who during fully healthy condition took life leisurely, leaving reform to the reformers, in an onsetting hypomania gradually developed an eager interest in the neatness of the public thoroughfares of Boston. Possessed by such interest, she wrote the mayor of

the city, urging him to promote legislature against throwing wastepapers on the Common. The same woman, in another attack which occurred while she was staying in Paris, began to be concerned somewhat disproportionately with the unhygienic effects of women's skirts. In her desire to reform the mode of dress of her fellow-sisters, and in her exalted confidence in her own proficiency in promoting such reform, she found it proper to walk around in breeches, thus making herself the laughing-stock of the pedestrians on Boulevard Montparnasse. These are examples of typical hypomanic acts, characteristic of one of the onset phases of the manic-depressive disorder. Superficially they may seem altruistic enough, but the profound driving motive of the patient is the egotistic desire for self-display, and behind the act is an undue egotistic over-evaluation of his own capacity in life, coupled with a diminished appreciation of what his position properly permits.

If the manic-depressive psychosis sets in with a mood of inadequacy, the picture will in general look as follows. The egotistic tendency of the patient to over-consider and over-evaluate any matter of personal reference here leads him to develop undue touchiness concerning himself; this promotes worry; it exaggerates, subjectively, any difficulties, gives a nagging edge to half-forgotten conflicts and adds new ones. It also makes him abnormally over-conscientious in his own duties and activities, which again increases his subjective difficulties in getting along with his daily routine. The divine and healthy capacity of *laissez faire* seems to have left the patient entirely. His pencil breaks as he figures an account; he becomes unduly vexed. His mail is delayed; he thinks the postman purposely goes to the neighbors first. The office boy has a cough; he thinks Jack coughs in order to annoy him. His chief is in a hurry; he thinks that the latter did not greet him in a friendly manner because he is dissatisfied with his work. The closing of his books shows a little less profit than the previous month; he thinks that business is going to pieces. He has a pain in his back; he thinks, "I will be laid up for

some time and lose my position." Andy tells Sandy a joke in the street car; he sighs, "I used to like jokes formerly." A bridal party exits from a church as he passes; he thinks dolefully, "I, too, was once in Arcadia."

Hundreds of small annoyances like these are typical of the inadequate onset of the manic-depressive disorder; hundreds of vaguely morbid reactions due to the egocentric flow of all associations, which gives every incident, even the most insignificant one, a personal reference, and a personal reference which is colored by the mild melancholia of the inadequate mood.

Whether the onset of the manic-depressive disorder is characterized by euphoria or by feeling of inadequacy, the coming to the surface of egotism sets up a vicious circle of profoundly fatal significance. The reaction tendencies of egotism, each time they find expression, reinforce the general egotistic inclination, and make the egotistical attitude habitual. It leads, in both phases of disorder, to over-exertion and to physical and mental stress, thus producing fatigue which assumably promotes further breaking down. It intensifies also the mood component of the condition, causing it to grow, in one phase, into a monstrous feeling of omnipotency; in the other, into a paralyzing or frantically agitating depression. By this time, however, the second level of profundity of disintegration is probably already reached, and its specific symptomatology complicates further the disease picture.

Another manifestation of the preponderance of egotism in the onset stage of the manic-depressive disorder is the gradually decreasing suggestibility of the patient. Both the euphoric and the inadequate patients seek an audience, the former for his hypomanic schemes, the latter for his complaints; and both see with egotistic satisfaction that attention is paid to them. But, if you should attempt to contradict one of their statements or to suggest a modification of some part of it, not only are they immune from such influence, they may even respond to it with vexation and irritation. You cannot persuade the hypomanic that his device is disproportionate to

the need, nor can you convince the anxious that his worry is out of proportion to the situation. Your word is feather-weight as compared with the lead-weight of their hard-cast opinions. This makes corrective interference from the side of the physician hopelessly ineffective, and, from the very beginning, psychotherapeutic practices of little avail.

The appearance of egotism in the onset stage of the manic-depressive disorder is the general rule, although exceptions are seen, and I believe it proper to refer this phenomenon to a breaking down of the lighter inhibitions which during normal healthy condition have been maintained by repression. The manic-depressive patient should accordingly be thought of as a person who prepsychotically has been able to handle his egotistic inclinations so as to check by repression their most offensive expression. This would have resulted in the accumulation of a subconscious personality-part of exaggerated egotistic character, which may have conflicted subconsciously with the nuclear self, but the desires of which would have been eliminated from conscious reflection and overt expression by a process of repression. We are, indeed, forced to such assumption for the simple reason that an acute disease cannot possibly be conceived of as creating personality traits; it can mostly bring out traits which previously have had a hidden existence as part of the individual. As, undoubtedly, the concealment of these traits has been the result of an inhibitory process involved in adaptive integration, the coming to the surface of the hidden tendency naturally suggests an opposite principle or a breaking down of inhibition. Such breaking down of inhibitions would again indicate the working of a disintegrative process and the symptoms referred to would be explained ultimately as the result of it.

If this interpretation is correct, we have to ascribe some significance to the constitutional E-disposition as promoter of the manic-depressive disorder. This is evident first in the respect that the E-disposition has made difficult the more successful mode of adaptive inhibition which is attained by the process of sublimation, leaving, as the dominating possibility,

adaptive integration by repression. The latter mode of procedure leads, as we have previously seen, to the establishment of the egotistic subconscious personality-part. But the effect of the E-disposition stretches, indirectly, even further, in that this egotistic personality-part, for the accumulation of which it is responsible, once brought into dominance by the disintegrative process, sets up the vicious circle I have just described and increasingly accentuates its fury. The rôle of the E-disposition in the manic-depressive psychosis was called to attention, for the first time, in my article on the manic-depressive psychosis of 1926 (Bib. ref. 2). I have had no reason since to modify my view, although I fully appreciate the fact that there is no theoretical ground whatsoever why a person who has been capable of successful sublimation in the major part of his adaptive habit-formation, under the influence of a sufficiently strong disintegrative agent, may not also develop the typical manic-depressive syndrome.

Among symptoms, other than the egotism, which appear in certain cases in the onset stage of the manic-depressive psychosis and which we can refer also to a first breaking down of the weaker, acquired adaptive inhibitions, are a number of obsessive tendencies, both of the compulsory and the phobic type. In order to understand their appearance we have to keep in mind that a mild form of such tendencies is not uncommon in some people even during normal health. We have all met individuals who display a vague touch of the famous *folie du doute,* those people, for instance, who have to return twice to assure themselves that they locked the safe on leaving their office, or that they put the wet umbrella in the rack and not on the floor, and so on. Other forms of compulsions are common in children. We have heard about the boys and girls who always try to walk only on every third pavement stone, or who have to take two steps at a time in the stairway even if the situation requires no unusual haste. I can myself record such a compulsion which haunted me during a certain period of my childhood. It consisted in an imperative impulse to do a very definite series of acts always three times, nine times, or

twelve times. I can remember having a notion that if I did this, I would find things in the street. It is true that I was an unusually lucky child in finding lost objects on the sidewalk, a fact that I can explain now by a habit which I have maintained throughout my life of carrying my head somewhat bent forward in walking and consequently my eyes on the ground, but how I came to associate this luck and its promotion with the multiplication of certain acts, I cannot give the least account for; yet I have to admit that there are occasions still when the impulse to such multiplication comes up.

What I want to call to attention by my examples is the fact that compulsive desires of the kind described are probably rather common. How they develop is difficult to say; this, however, is true that the healthy, normal adult is capable of checking them whenever they appear; he checks them not because they conflict severely with his ethical ideals, but merely because they seem absurd and laughable and would make him mildly ashamed if he fell for them in society. They are, we may say, under a continual mild inhibition by repression. Such being the case, it would again seem highly probable that the acute coming to the surface of similar compulsive tendencies is due to a general disintegrative process which breaks down the above inhibition. Exaggerated *folie du doute* is not uncommon in a beginning depression, and even the absurd compulsions of the type shown in children sometimes become manifested in the onset stage of the psychosis. Thus I have seen a mildly inadequate patient develop a compulsion to step over the threshold of his room always with his left foot first and, if by mistake he should have done it the other way, he had to return and do it again in conformance to his compulsion. In extreme instances, abundant series of such compulsions may nearly paralyze any conduct expression of a patient.

The obsessions of the phobic type which oftentimes appear in the manic-depressive psychosis already in the onset stage, should be understood along similar lines. We have all, even normally, so called idiosyncrasies, individual likes and dis-

likes. Sometimes our dislikes may be rather unreasonable and not rationally founded and in such cases we keep them to ourselves, we do not talk about them and we check their expression. This is a manifestation of adaptive inhibition, and like the other adaptive inhibitions they break down in the disease. Thus idiosyncrasies and the tendency to develop such may become exaggerated, and their expression become devoid of proper social checking. The step from dislike for an object, particularly as accentuated by a loss of critical inhibition, to fear of the object is very short, and in manic-depressive patients we may observe real phobic tendencies attached to an object.

Although we may acknowledge that the appearances of obsessional tendencies in the psychosis have their root in the individual moulding of the patient by his own past experience and, thus, may have a psycho-genic basis, these tendencies are of no psycho-therapeutic significance in the sense that they indicate a profitable lead to curative mental exploration, as is the case in certain psychoneuroses. It is not so much the specific compulsions and the specific idiosyncrasies of early psychogenic origin which come to expression, as it is the general obsessional tendency, and this tendency may seek a variety of objects in the present. In certain instances, however, an idiosyncrasy which has existed prepsychotically may also be brought into exaggerated relief and may be reacted to openly in the disintegrated condition. In either case, whether it is only the general obsessional tendency or the specific, previously cast obsession which manifests itself to extreme, it holds true that the abnormal reaction is one that is handled and controlled properly during healthy life and will again become handled and controlled as soon as the disintegrative agent is removed and the normal state of mind re-established.

The symptoms I have spoken of up to this point, that is, the gradual attainance of dominance of the normally checked egotism with all its accessory ramifications, and the mild obsessional tendencies which come to the surface in certain cases, are not yet considered as psychotic. The depressive syndrome,

in the mild form described, would still class the patient as a case of psychoneurosis, neurasthenic type, and the mildly manic syndrome would only be mentioned as a hypomanic condition. The conduct of the patient becomes definitely psychotic first, when the supremacy of emotional life begins to impair gravely his adaptive judgment. This goes parallel with the development of liability for tantrums, when detached impulses immediately on their evocation force themselves into expression with supreme intensity and without critical deliberation. As one of the aims of adaptive integration consisted in the control of crude instinctive reactions, a control which modified these from tantrums into deliberate and civilized expressions of desire, we may properly interpret the liability for tantrums of the psychotic patient as the result of a further breaking down of adaptive inhibitions and thus of a progressive process of acute general disintegration. The stage of disorder where this liability is the most pronounced disease manifestation I have chosen to call the second level of profundity of disintegration.

The liability for tantrums on the second level of profundity of disintegration develops slowly and gradually, just as the coming to the surface of egotism in the onset stage. In fact this liability may be said to grow gradually out of the state underlying the vaguely hypomanic act on the one hand and out of the somewhat undue tendency for worry and mild apprehension on the other. Its early expressions may be fairly innocent, as in the case of a young girl who has recently been under my observation. The first act that appeared peculiar in this girl was that, one afternoon when her parents were away, she suddenly got the impulse to go to a moving picture theatre, an impulse which she obeyed. This was in itself not very startling, because she had done so many times before; but the unusual thing was that, in the sweep of her impulse, she forgot entirely to leave a note to her parents telling them where she had gone, as had always been her rule previously. In other words, the supremacy of the impulse removed from her mind the normal appreciation of the forms under which

she could properly satisfy it, removed some of the critical deliberation which naturally should have accompanied the carrying out of the impulse. Her next impulsive act was more severely maladjusted. She had a "beau" in ———, New York, whom she eagerly desired to see. One day her parents found her with her valise packed and on her way to leave for the train to ———. She had not told about her intention and she was not sufficiently furnished with money for the trip; furthermore, as she was not of age, she should not properly have undertaken the journey without company.

Small episodes like the ones described mark the onset of the deeper disintegration which leads to the return to the tantrum level of conduct. In its more extreme manifestations, as seen in the fullblown psychosis in mentally clear patients, the supremacy of detached impulses with their emotions produce not only grave judgment defects but also misinterpretations of facts and delusions. Here the state of emotional hypersensitivity generates rationalizations in accordance with its affective tone, which are often sheer absurdities. A vague noise in the room, for instance, may evoke frantic fear and may be interpreted as the indication of the presence of a murderer or what not. A feeling of guilt may take such dimensions as to produce a belief in the patient that he is condemned by God and man and that he has committed all the deadly sins in the world. And if you ask the patient to give an example of his sins, lo, he may mention a trifling matter, as a woman patient who told me that she was "Providence's outcast" because once, as a little girl, she had stolen a nickel from her father's desk without ever telling him. In other instances the imagined sins are absurd not in their triviality, but in their monstruous severity, as in the case of another woman patient, who, in her supreme feeling of self-guilt, claimed that she was killing all the patients on the ward, sucking out their blood. "Look at my hands," she used to say, "they are red, they contain the blood of all the patients. I am gradually killing them by sucking their blood." Another good example is a manic patient who, in his supreme desire to assert himself, transmitted

to me the following remarkable communication. Showing me a small scratch on his palm, probably contracted without his knowledge, he told me that this was the sign of stigmatization and indicated that he was a saint and had an important mission to carry out. In further support of his saintly eminency he brought out the additional fact that he was born on a Sunday. When I contradicted the pretended saint, he turned into supreme anger, which on my smooth withdrawal of the contradiction, changed into a jovial attitude, in which, with supreme haughtiness, he condescended to forgive me.

In the state illustrated by my examples the patient's sense of proportion, his evaluation of the proper relative significance of things, is entirely distorted by the supremacy of his emotions. Not only does he misinterpret outside happenings and situations, but he cannot even handle rationally the associations of thought which may come to his mind by very insignificant instigation. The other day, as I was opening the closet in which I keep my stationery, this thought suddenly came into my head. "There is a corpse in the closet." What brought out this idea I do not know, but I imagine there existed some hidden association between the door and my act of opening it and some incident, possibly from a detective story, that I had read on some occasion. Naturally I gave no consideration to the thought but proceeded to open the closet and fetch out the material I desired. Adjustive inhibition. If I had been a manic-depressive patient, the matter would have developed differently. The idea of the corpse in the closet would have evoked supreme fear. This would have reinforced my belief in the realness of it and, instead of carrying out my intention to open the door, I would have rushed out and told people of the dead man and brought them back with me to get him out. A parallel, in the manic phase of the manic-depressive disorder, to this imaginary situation may be depicted fictitiously as follows: A manic patient walks about in the hospital garden. He happens to go by a workman who is leading along his horse and wagon. Suddenly this thought enters into his head. "The man maltreats his animal." This

is due to some hidden association, let us say, the association of the horse and man with the realistic description of the cruel beating to death of a horse, in the first chapter of Dostijevski's *Crime and Punishment*. The thought immediately evokes in the patient supreme indignation, which reinforces his conviction of its trueness. He rushes to the workman and reproaches him, threatening to mention him to the Society for the Prevention of Cruelty to Animals. Such conduct of the manic patient should not be confused with the impulsive striking of the schizophrene. The schizophrenic act apparently comes out of the clear sky and then dies off equally rapidly, without presenting any afterswell of affect. The manic act, on the other hand, is carried by a gradually increasing and gradually abating emotional wave. If, during its course, you should approach and soothingly attempt to defend the abused workman, the patient will get only more intensively excited, and he will soon include you in his angry reproach and criticism. A corresponding development would not be characteristic of the schizophrene.

Such occurrences as the ones referred to above are frequent on the background of the tantrum liability which is prevalent on the second level of profundity of disintegration. Any emotion may in this state of disintegration attain tantrum supremacy, lust, anger, fear, food-hunger, retrospective remorse, food-repulsion, curiosity, and so forth; and we may see our patients thrown rapidly between extreme states of varying emotional dominance. All these states may produce each its own range of delusions, as has been exemplified above. A rather interesting variety is the delusion that the patient's food has been tampered with, a common occurrence in cases of depression. It is most probably explained as a superstructure on extreme food-repulsion, or as a superstructure on conjoint supreme food-repulsion and fear.

Tantrums have been described as primitive modes of reaction. With this in view it seems rather significant that, if we want to find really strong descriptions of human tantrums, we have to go to the early classics, like Homer and Sophocles,

who, although great poets, were somewhat crude psychologists. Nobody thinks of Oedipus Tyrannus as a case of disintegration; yet there is no more powerful literary illustration of the vicious retrospective remorse, seen in certain depressed patients on the tantrum level of disintegration, than his famous lamentation before the senator and Creon:

> I know not how
> With seeing eyes I could have looked upon
> My father—coming to the under-world,
> Or my poor mother, when against them both
> I have sinned sins, worse than a halter's meed.
>
> .....
>
> If there were any way to choke the fount
> Of hearing, through my ears, I would have tried
> To seal up all this miserable frame
> And live blind, deaf to all things. . . .
>
> —Cithaeron! wherefore didst thou harbour me!
> Why not at once have slain me? Never then
> Had I displayed before the face of men
> Who and from whom I am! . . . .
>
> .....
>
> Wedlock, wedlock,
> You gave me being, you raised up seed again
> To the same lineage, and exhibited
> In one incestuous flesh son—brother—sire,
> Bride, wife and mother; and all ghastliest deeds
> Wrought among men! . . . .
>
> .....
>
> Out of this country cast me with all speed,
> Where I may pass without accost of men.
>
> .....
>
> never more
> Be this my native town burdoned with me
> For living inmate; rather suffer me
> To haunt the mountains— . . . .

The undue magnitude and egotism of the hero's lamentation, which makes it so much like the expressions of self-guilt of the non-seclusive depressed patient, is well appreciated by Creon when he reproachfully interferes:

> Not as a mocker come I, Oedipus,
> Nor to reproach for any former pain.
> But you—even if you reverence no more
> Children of men,—at least so far revere
> The royal Sun-god's all-sustaining fire,
> Not to parade, thus flagrant, such a sore
> As neither earth nor day can tolerate,
> Nor dew from Heaven! . . . .[1]

A rather pathetic illustration of the second level of profundity of the manic-depressive disease is offered by the following extract from a note on a young girl patient, sixteen years old and of good family, who came to the hospital, a human bundle of sheer lust.

"The patient was seen a short time after admission by the writer and Doctors L., W., and G. She remained quietly in bed for some seconds; then she sat up, stretched her arms towards the writer, whom she addressed as Dr. S., and tried to embrace, crying out "let me hug you." From then on she displayed rather free and unconstricted activity of a more or less erotic type. She talked continually in a rather modernistic fashion, using frequently such expressions as "making whoopee," "getting drunk," "bearing children," etc. Her mood was definitely exhilarated. She was superficially clear, knowing that she was in a hospital and being able to recall the names of Doctors L., W., and G. correctly. There was much talk about a young man whom she called Dickie. "Can I have Dickie, quick. It is anyone's privilege to make whoopee. Oh, it's wonderful. I am so happy, I can't talk. Who wouldn't be, having Dickie." Here the writer asked the patient how she happened to come to the hospital. She replied: "I came here because I loved you, and had to have you. You know what happened up in ———? I got drunk and Dickie said I might have a kid without wanting it." Upon this the patient invited Dr. W. to sit on the bed and as he refused she purposely thrust herself partially out of the bed to embrace him."

[1] Sophocles, *Oedipus Tyrannus* (English verse by Sir George Young). Everyman's Library. London, J. M. Dent & Co., and New York, E. P. Dutton & Co., date of publication?

The continuation of the note is by the nurse who attended the patient:

"The patient became somewhat more composed after the interview. She coughed a good deal, apparently an affectation. In the afternoon she began to scream for Dickie. In the evening her conduct became very dramatic. She would throw herself from the bed to the floor, beat her head, scream loudly, throw pillows and bed-clothes about. In the meantime she called for Dickie. When opposed in her tantrum-like conduct by the nurse she tried to strike the latter with a bed slat and to choke her. She was temporarily placed in a camisol and transferred to the ——— House. There she continued very noisy, constantly calling for Dickie and talking about making whoopee. "Bring Dickie here. I can't do without him. I must have my Dickie, and don't fool me again." After this she alternatingly sobbed, screamed, and threw herself on the floor. . . ."

The above note needs no comment. It speaks sufficiently clearly its own drastic language.

A rather curious inclination that may be referred to as a very primitive expression of the uncritical working of the supreme acquisitive instinct, is the desire to gather and hide food, which can be observed in some manic patients.

It should be noted here, although the matter can be taken up more fully only later on, that, in spite of the fact that the liability for tantrum reactions is a general characteristic of the second level of profundity of disintegration, there is a tendency for these reactions to form certain definite constellations which vary in different patients. The variation of constellation is, broadly conceived, between patients in the manic and the depressed phase of the psychosis, and as the determinant of the constellation we can, at present, only mention the mood of the two phases. The general feeling of omnipotency selects and favours a constellation of tantrums in which assertion, anger, lust, sometimes curiosity and food-hunger predominate, while the general feeling of inadequacy selects and favours a constellation in which retrospective remorse and

fear, and, not infrequently, food-repulsion predominate. The fear in the inadequate mood sometimes throws the patient into defensive conduct and anger, but this anger never comes near the frantic rage of the manic patient.

The less severe symptoms of the onset stage of the manic-depressive psychosis, notably, the predominating egotism and the obsessional tendencies, naturally do not disappear when the tantrum level is reached. They are still present, intensified; the egotism being the general undertone of the total condition and the obsessional tendencies expressing themselves episodically, now even more absurdly than in the onset stage. This is equally obvious in the mentally clear manic as in the non-retarded, non-seclusive depressed patient, a matter to which I have given special consideration in a paper of 1926 (Bib. ref. 2). In the former we have an absurd self-overevaluation, in the latter an absurd touchiness in personal concerns; in both we have complete immunity from suggestions contradictory to the patient's set attitude.

The symptoms so far described in this monograph, representing the first and second level of profundity of general disintegration, signify in themselves no impairment of the general mental clearness of the patient. The latter knows his actual environment and is oriented as to time and person. If his coöperation can be obtained, he is capable of performing a variety of clinical tests of mental proficiency. But, very frequently, the manifestations of the second level of profundity of disintegration are episodes which occur on the background of a condition which represents a far more severe degree of disorder.

This latter state is characterized by the fact that the organization and control of all the mental propensities under a higher dominance, which selects impulses by allowing and inhibiting drives in a purposeful manner, is, as it seems, entirely broken down. The mind of the patient is a whirlpool of simultaneously active impulses, some urging him in one direction, others in another, oftentimes inhibiting entirely all expression of activity and always prohibiting sustained purposive con-

duct. This condition represents the complete undoing of everything that normally is maintained by adaptive integration, and may thus, I believe, be referred to properly as the manifestation of the third or profoundest level of a temporary, general, disintegrative process.

On the second level of profundity of disintegration we have still sustained directed activity, carried by a supreme emotion. This sustained activity may also be called purposeful in a primitive sense, that is, it is purposeful in a similar way as the instinctive tantrum reactions of the beast; not quite, however, because the tantrum reactions of instinctive behavior in the beast are released by an object that is as a rule adequate to the purpose, while in the manic-depressive patient the tantrum reaction is mostly instigated by an object out of proportion to any objective need. On the third level of profundity of disintegration, any sustained activity is continually interfered with by the conflict of other simultaneously activated, disparate impulses. This state of affairs which, I believe, is concomitant to the most profound disintegration possible, is called by the psychiatrist, the condition of "confusion." The symptoms which he acknowledges as indicative of this state are such as flight of ideas, distractibility, stupor with resistiveness, and so forth.

In a recent paper (Bib. ref. 3) I have advocated that such broad usage of the term "confusion" is not only improper theoretically, but also inefficient for the practical purpose of discriminative, clinical analysis of cases. I have also suggested *(ibid.)* a far more restricted definition of the state of confusion. For the progress of my present discourse it is necessary that I review the essential features of my theory concerning confusion.

The view I have propounded concerning the nature of the state of confusion maintains that this state is essentially a condition, in which directed conduct is blocked by the fact that many disparate impulses, urging the sufferer towards incompatible directions of activity, are reciprocally inhibiting each other. Such state of "confusion proper" is always of

only short duration and can be illustrated best by an example. Suppose a person finds himself in the middle of a well-trafficked city street. Suddenly, he sees a number of motor-cars approaching from every direction and apparently aiming at him. This situation may bring about a complete blocking of escape conduct because the subject is incapable of deciding the route of activity. Such deadlock of disparate impulses is, I suggest, exactly what should be called "confusion proper," and in denominating it thus, we do not violate the popular usage of the term. The confusion only lasts for a moment; it may become rapidly dissolved into flighty activity. Our subject may rush, now in one direction, now in another—a familiar sight—until, by trial and error, his conduct leads to salvation or to catastrophe; the confusion may also be solved into critical, one-directed movement along one really purposeful route, and will, then, be more likely to result in salvation. Either way that conduct takes place, the act of responding overtly to the situation signifies a solution and a disappearance of the confusion proper. This example illustrates confusion, determined by a conflict as to the routes of obtaining one single goal, but naturally confusion can be produced equally well by a deadlock between impulses towards incompatible goals.

The interpretation I have suggested of "confusion proper" regards this state as a condition which, as far as motor expression goes, is completely negative, being a condition of motor deadlock and immobility. This immediately dethrones the clinical symptoms of flighty conduct, of distractibility, and of resistiveness, etc., as expressions of "confusion proper." In fact, the flighty conduct of our disintegrated patient signifies exactly the same thing as the flighty conduct of the normal man in the situation of my above example. It indicates a solution of the conflict of the confusion by a sequential reaction, one at a turn, to the disparate impulses which a moment previously may have deadlocked each other. Clinically, it is possible and profitable to discriminate between three varieties of such sequential reaction to the disparate con-

flicting impulses, and the mode in which these vary is in regard to the amplitude of the individual responses to each consecutive impulse. These three varieties may be rubricated briefly as follows:

1. Flight of ideas and of directed conduct.
2. Indefinite sway of activity (contentless restlessness).
3. Incoördinate play of small, irregular movements.

The first rubric refers, on the one hand, to the conduct of those patients who continually produce a stream of speech, a stream of speech, however, that never carries to a conclusion a definite trend of thought because it is always sidetracked by conflicting ideas. The agent which turns the switch is oftentimes merely the most superficial word-association; at other times, it may be a new trend of thought set up by outside impressions and occurrences. On the other hand, it refers to overt motor conduct produced by the same whirlpool state of mind, as exemplified, for instance, by the following mode of behavior. The patient, on your entrance, rises immediately to meet you, perhaps stretches out her hand to greet you; before you have time to take her hand, however, she is off on another activity. She may start for the bed and begin to smooth the bed linen; then she sees a piece of orange peel on her bureau; she heads for it, picks it up and is on her way to the waste basket, but again she is distracted by something outside; she turns towards the window and drops the orange peel on the windowsill, and so forth. Here we can see a direction of each impulse, we can see that it has an aim, but the goal is never reached because one impulse is interrupted continually by another before any of them has had sufficient time to be brought to completion. In most instances of such flight of directed conduct the picture is complicated by the coinciding occurrence of the speech-motor flight of ideas.

The second rubric refers to a clinical picture in which the amplitude of the consecutive reactions to the disparate impulses is less. The patient presents an indefinite sway of apparently purposeless conduct, which probably merely means that, now, the amplitude of each initiated impulse is too

small to allow us to see what it intended. This gives an apparent picture of sheer contentless restlessness, aimless wandering. Verbal flight does not as a rule accompany this form of conduct, but, frequently, there may be an incomprehensible, sustained moaning or an incomprehensible chatter.

The third rubric refers to a condition when the amplitude of the consecutive reactions has decreased so as to make observable only small, irregular, incoördinate movements or jerks. Such reaction may or may not be accompanied by incomprehensible moaning.

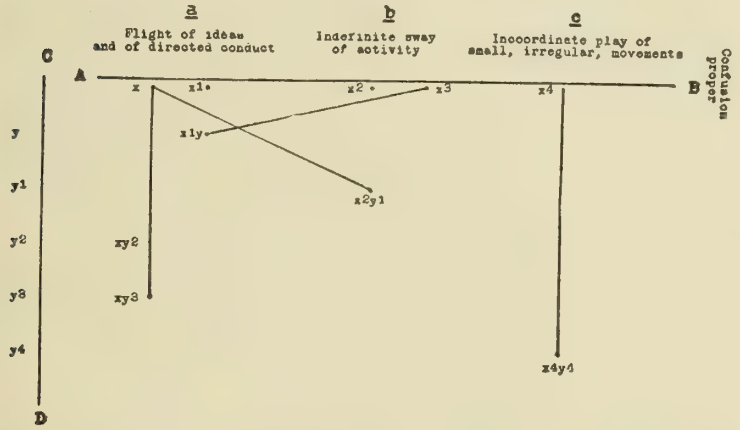
"Confusion proper," which is expressed in complete immobility, is never seen as a prolonged condition, either in the normal man or in the psychotic. This does not exclude that the patients on the third level of profundity of disintegration are, in all probability, extremely liable to suffer very frequently momentary deadlock between disparate impulses. Such deadlocks represent, we may assume, short pauses in the continuity of their consecutive reaction stream.

It is true that there is a state on the third level of profundity of disintegration which approximates prolonged immobility, the so-called depressive stupor. I have reason to believe, however, that this state is not the result of prolonged deadlock between disparate impulses, but is due rather to a general lowering of the whole vital level of the sufferer, which may be secondary to a condition of complete, or nearly complete, exhaustion of the effector system of the body. This consideration leads up to the discussion of what we may call the "two-dimensional variability" of the syndrome of the third level of profundity of disintegration.

The three varieties of sequential reaction to the disparate impulses, characteristic of the third level of profundity of disintegration, namely, the flight of ideas and of directed conduct, the indefinite sway of activity, and the incoördinate play of small, irregular movements, represent reactions which are differently distant from "confusion proper" or immobile deadlock. The flight conduct with its relatively large amplitude of individual reactions would signify a further distance

from "confusion proper" than the indefinite sway of activity with its smaller amplitude. In the same way, the indefinite sway of activity would signify a further distance from the true deadlock of "confusion proper" than the incoördinate play of small, irregular movements with its still more minute amplitude of motion. This situation we may express as distances on a horizontal line (A-B) at the right end-point of which (B) we place "confusion proper" or complete deadlock (compare Fig. 1). The portion of the line correspond-

Figure 1



ing to (a) would then indicate the flighty conduct, the conduct form which is farthest from "confusion proper," the one corresponding to (b) would represent the indefinite sway of activity, which is nearer to deadlock than flight, and the portion corresponding to (c), finally, would represent the incoordinate play of small, irregular movements, the reaction form that comes nearest to "confusion proper." The continuity of the line indicates a fact that is clinically observable, namely, that there is a gradual transition from one of the reaction forms into the other, presenting both mixtures of the two bordering ones and qualitative intermediates. The sliding, in one or the other direction, along the line (A-B) represents one of the modes or dimensions of variability of the

condition of the third level of profundity of disintegration. We may assume that sliding towards the right, that is from flight to incoördinate play of small, irregular movements, is concomitant to an increase, within the third level itself, of profundity of disintegration; in other words, we may assume that the patient presenting the incoördinate play of small, irregular movements is more deeply disintegrated than the one who presents the indefinite sway of activity, the latter being, in his turn, more deeply disintegrated than the one presenting flight of ideas and of directed conduct. If this is correct, it would allow us to continue the line (A-B) in direction towards the left, and on this continuation we would have a right to mark off the second and the first level of profundity of disintegration, those levels being stages in the same progression. I shall later submit an independent diagram of such kind. For my present purpose it is profitable to consider merely the part of this progression which is projected on the third level of profundity of disintegration.

The other mode or dimension of variation of the syndrome of the third level of profundity of disintegration we may understand, if we imagine that the total of the horizontal line (A-B) slides up or down a vertical line (C-D), the top point of which (C) represents a state of high general vitality and the progression of which, downwards, represents gradually decreasing vital intensity, or gradually increasing "dazedness." By means of this diagram, we may picture a number of the daily, or weekly, or even hourly variations a patient may present on the third level of profundity of disintegration. A certain patient may, for instance, on one day show active and intensive flight. His condition may be expressed on the (a) portion of the horizontal by the point (x), and his level of vitality may be laid on the height of (C) on the vertical. On a following day his flight may be equal in speed and distractive jumpiness, but the whole activity may be carried by a generally less vital urge. I mean that, if, for instance, the speech-motor flight of the patient were taken down verbally and written out on the two different occasions, it would look

qualitatively identical or nearly so on the paper. There also would be no marked difference in the amount of ideas produced per unit of time. On the other hand, the two productions would vary in a respect that cannot be expressed in the written account, namely, in the general intensiveness of urge by which they were carried. In the second instance, the patient would thus be equally flighty as in the former, but his flight would be conjoined with a certain "dazedness." The projection of his state (xy2) would still fall on the same point (x) on the horizontal, but its level on the vertical would be considerably lower than before, would be represented, let us say, by the point (y2). Still later, his dazedness may be noticed to have increased but there is yet the same qualitative expression of obvious flight. In such instance (xy3) we may mark his state as still lower on the vertical, let us say on the height of point (y3), while his position on the horizontal remains point (x), and so on. In the same way we may observe how a patient presenting the incoördinate play of small, irregular movements, which indicates a condition near to "confusion proper," passes from day to day along the vertical. On one visit we may find him in bed showing the vague movements of small amplitude that sometimes even simulate mere coarse trembling. His eyes are fully open and shine brightly in a manner that suggests high vitality, even if it is a vitality which is continually blocked in the maintenance of directed activity. On the following visit we may find him with the same motor symptom, but now there is a veil on his eyes that makes you feel that his condition is different, and this difference impresses itself upon you as a difference in general vitality. His first diagrammatic position may be indicated by the point (x4) on the horizontal, on the level of (C) on the vertical. His second position (x4y4) is still indicated by the point (x4) on the horizontal, but his level on the vertical is lower, we may say on the height of point (y4).

The transitions we have now exemplified are transitions which are diagrammatically represented by direct movement down verticals (x-xy2-xy3) and (x4-x4y4). Just as we can

observe such transitions we can also observe subsequent transitions in the opposite direction, that is from a lower to a higher vertical point; in other words, a patient, while maintaining the same quality of conduct, may be considerably dazed one day and, on the following, be again extremely vital. But we may also observe transitions along oblique lines in the diagram. One such transition is indicated by the line (x-x2yl). This transition would clinically conform with a change as follows. On one occasion the patient is vitally flighty, on the following, the quality of his conduct has become modified into the indefinite sway, and at the same time he seems less vital, somewhat dazed. Again this development downwards and towards the right may, on a subsequent occasion, have changed back, and you find your patient again flighty and vital. A transition from a higher right point to a lower left (x3-xly), which would be exemplified by a change from indefinite sway of activity with high vitality into flight of low vitality, can also be observed, just as any transition in purely horizontal directions (x-x4 or x4-x).

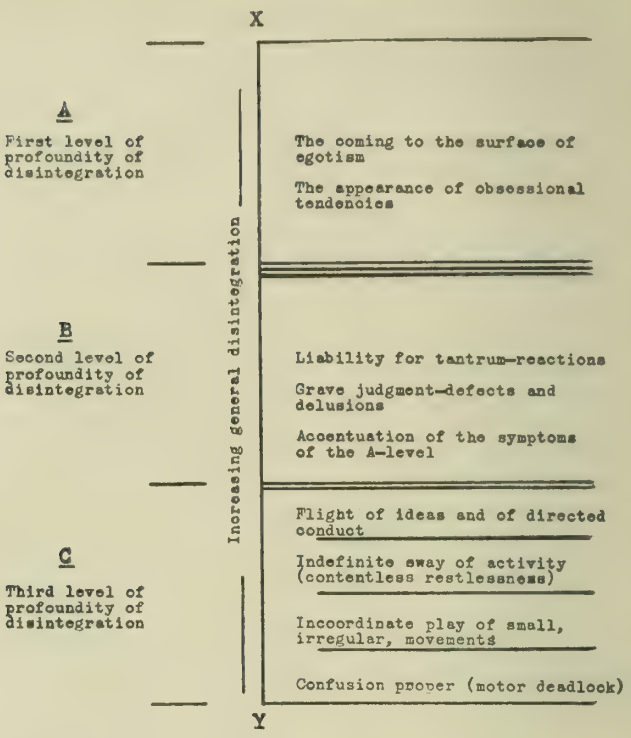
It is obvious that, whenever transition along the vertical, no matter from what point on the horizontal, has reached a certain level, that is, whenever the general vitality reaches a certain minimum, any overt conduct will cease. This gives us what I believe to be the true depressive stupor which is occasionally seen in our patients. There is another condition of immobility in the depressive patients, that is often mistaken for depressive stupor, but which to my mind is determined by a far different principle, a state which probably approximates the sham-death reaction to extreme fear. This state, however, can be discussed more fully only when we have dealt with the three "imperial moods" of the manic-depressive psychosis, notably the general feeling of unreality.

Concerning the physiological aspect of the two-dimensional mode of variation of the state of the third level of profundity of disintegration we can only speculate. I have already referred the transition along the horizontal of the diagram to minor variations in the depth of the disintegrative process,

which would mean physiologically to minor variations in the depth of general dissociation of the higher central nervous system, especially the cortex of the brain. I have also pointed out, in the beginning of this paper that, if the major symptoms of the manic-depressive psychosis can be properly interpreted psychologically as generally disintegrative, the concomitant general dissociation of the brain can only be referred to a toxic influence. With this in mind we may conclude that the slide from left to right on the horizontal of the diagram is determined by an increase in the toxic profundity of the disease. Such increase may be due, reasonably, to the addition of the effect of fatigue poisons to the toxic state, an addition which would be the result of the intensive activity involved in the sequential reaction to the disintegrated impulses. Contrary to this, it is suggestive to refer the vertical component of the transition of the syndrome of the third level of profundity of disintegration to the other component of fatigue, namely, the pure exhaustion of the energies of the effector system, involved in the sequential reaction. If this should be the case, we might refer the horizontal slide from left to right to the toxic component of fatigue alone; the oblique slide from left to right to a joint effect of both the toxic and the exhaustive component of fatigue, and, finally, the straight vertical slide to the exhaustive component of fatigue alone. All this, however, is highly hypothetical and has been tentatively submitted for overthrow or verification.

At this point in my thesis it is profitable to summarize, in a diagram, all the symptoms which have been taken up for discussion. These, as we have seen, have all been interpretable as symptoms of general disintegration, all representing a more or less complete temporary undoing of the attainments that, in the psychogenic growth of personality, the process of adaptive integration has built up. There are three levels of such disintegration distinguishable in the psychosis, each level being indicated by its own peculiar symptoms. A diagram of these as they gradually appear with increase in the depth of the disintegrating process can be given as below (Fig. 2).

Figure 2



The vertical line (X-Y) in the diagram represents a dimension along which we may consider that the general disintegration of personality gradually increases. This vertical is divided by horizontals into three main divisions, (A), (B), and (C). The top division (A) represents the beginning of the disintegrative process and embraces the onset symptoms of the psychosis, as far as these can be referred to disintegration. Among these we have to note, on the one hand, the coming to the surface of the egotistical personality-part which, during normal healthy condition, has been handled and sufficiently inhibited by the process of repression. On the other hand, we have to note, in certain patients predisposed by psychogenic experience or possibly, also, by a constitutional fac-

tor, the appearance of vague obsessional tendencies, mild compulsions and idiosyncrasies, the latter sometimes having a close resemblance to object-fixated phobias.

The (A)-division of the vertical, corresponding to the first level of profundity of disintegration, has been marked off from the second division (B) by a triple horizontal, because I want to emphasize strongly that the transition from (A) to (B) represents the transition from a state which simulates the psychoneuroses into a definitely psychotic state.

The (B)-level, or the second level of profundity of disintegration, is characterized chiefly by a liability for tantrum reactions. Non-integrated detached impulses seem to take on undue supremacy whenever they are activated, and this is naturally accompanied by a preponderance of affective as compared with rational, logical judgment. In its extreme ramifications this situation results in a grave impairment of adaptive judgment and in delusions. Aside from this supremacy of emotions, the second level of profundity of disintegration is also colored by the outlasting, in accentuated form, of all the symptoms of the first level.

The (C)-level of the diagram, or the third level of profundity of disintegration embraces all the symptoms which are spoken of by the psychiatrist as symptoms of confusion. According to the psychological conception of confusion which I have suggested, this usage of terms is not quite proper. "Confusion proper" should be understood as a temporary condition of complete deadlock between disparately striving impulses and would, thus, be overtly manifested in complete immobility. The psychiatrist's clinical indicators of confusion, in fact, represent the solution of confusion into a sequential reaction to the disparate impulses. Depending upon the amplitude of each such consecutive reaction we can distinguish, in a general way, three different clinical symptom pictures: (1) flight of ideas and of directed conduct, (2) indefinite sway of activity (contentless restlessness), and (3) incoördinate play of small, irregular movements. These symptom pictures represent, in the order given, states farther and

nearer to "confusion proper," or true deadlock. They also represent, I believe, states of increasing depth of disintegration. I have suggested that the prolonged relative immobility of so-called depressive stupor is not due to deadlock between conflicting impulses, but is rather the expression of a complete, or nearly complete exhaustion of the psycho-motor effector system involved in any form of sequential reaction to the disparate impulses. On the other hand, temporary deadlock between such impulses is probably frequent in the state of the third level of profundity of disintegration.

It is important to notice that all patients suffering from manic-depressive disorder do not sink down to the third level of profundity of disintegration. Some of them may stop on the second level, and, as the psychiatrist says, may remain mentally clear all through their psychosis, presenting merely the supremacy of disintegrated impulses with emotionally determined judgment defects. It should also be kept in mind that those patients who sink down to the third level, characterized by the chaotic conflict between disparate disintegrated impulses, may emerge, episodically, from this condition and show typical reactions of the second level. Thus they may slide from one day to the other between the third and the second level of profundity of disintegration, in which case they are spoken of by the psychiatrist as being one day confused and the other clear, or as being repeatedly in and out of confusion.

With the above diagram clearly in mind, it is interesting to trace back the recovery from the manic-depressive psychosis.

Patients who, during the depth of their psychosis, have occupied the third level of profundity of disintegration, may, in the recovery, very frequently be seen to pass back through the second and first stage. This is in concordance with what we would expect, as the gradual recovery means, undoubtedly, the gradual reëstablishment of the normal integration of mind in the reversed order of the process of breaking down. A particularly interesting period in the recovery can be observed when the patient reaches the first level of profundity

of disintegration. In this state his general attitude oftentimes seems sufficiently normal to make one feel that he will be responsive to advice and corrective suggestion. But frequently this is not true. There still remains the dominance over the patient's mind of the egotistic personality-part, the appearance of which was the very first sign of disintegration, and this may still, for a long time, prohibit corrective approach from the physician, and make his psychotherapeutic endeavour futile. With time, however, even this last sign of disintegration vanishes, and then first is the patient fully open to unbiased discussion of his own case. Consequently, as a matter of the mere chronology of the situation, the psychotherapeutic work can rarely be more than preventive of further attacks.

Another interesting feature in the same state of recovery is the influence of the patient's egotism on his retrospection upon his psychotic experience, an influence that delays his re-attainment of insight as to the nature of his past sickness. This influence is particularly striking in patients who, during the height of disorder, have conducted themselves extremely a-socially or in a socially repulsive manner. In such cases the patient's egotism does not allow him to accept his own psychotic past without self-defensive falsification. He is ashamed of it and, in order to evade the feeling of shame, he may build up delusions quite often of a mildly paranoid character. He may refer to his a-social conduct as a natural reaction on his side to some form of imagined improper treatment by relatives, hospital physicians, or nurses. In other instances, the patient seems to develop an amnesia for the past period, whether due to conscious repression or to other agents we cannot say with certainty. In many cases you get the impression that it is not true amnesia but merely one that the patient pretends in order to escape conversation about his sickness. True forgetting of long periods of deep disintegration to the third level of profundity, is probably common. This undoubtedly has its explanation partly in the fact that, at such times, the patient's general mode of experiencing

was rather indistinct, and partly in the fact that, after recovery, when his general mode of striving has changed from the chaotic discord of the disease into purposive, integrated, relative harmony of health, the feeling of "ego-reference" attached to his memory of the sickness is probably at a minimum, just because of this profound modification. The latter is in accordance with a principle which I have laid down in a paper concerning functional amnesia, and which may be stated briefly as follows. The feeling of "ego-reference" of our past experience, the feeling of its intimate belonging to or being part of ourself, is proportional to the degree by which we revive in the present the emotion of the event upon which we retrospect. In other words, only those memories get attached to them a strong feeling of "ego-reference," in which is strongly reflected the emotional quality which was part of the original experience. For further information concerning this principle I have to refer the reader to the article mentioned (Bib. ref. 5).

A certain number of patients, although a comparatively small one and consisting assumably of those who possess by nature a fair A-disposition, may be made by persuasion to take a humorous attitude towards their psychotic past, which promotes immensely their re-attainment of insight. The latter has been brought to attention strongly by Dr. Donald Gregg in an article of 1927 (Bib. ref. 1).

CHAPTER IV

The Three "Imperial Moods" of the Manic-Depressive Psychosis

The description and interpretation of the manic-depressive syndrome is not brought to completion by my present discussion. The symptoms described in Part II of my thesis are merely those which can be directly referred to a general disintegrative process. But there are other symptoms of the disorder which have a more complicated explanation. Such are, for instance the outer or objective distractibility, and the resisitiveness of certain patients, and the liability of other's to mistake the identity of people or to mistake the meaning of objects. These symptoms all occur in the conflict state of the third level of profundity of disintegration, but they cannot be directly explained merely by the disintegrative process, as they arise on the intermediate of a peculiar, subjective, general feeling of unreality which easily comes to predominate the patient's consciousness in the deeply disintegrated condition. More complex in its explanation than the directly disintegrative symptoms is, furthermore, the selection of affectivity on the second level of profundity of disintegration and also on the first. What I have in mind is the selection that, on the former level, is responsible for the tantrum constellations previously mentioned. This selection has also to be referred to the influence of general feelings, notably the feeling of omnipotency and the feeling of inadequacy.

The three general feelings, the feeling of unreality, the feeling of omnipotency, and the feeling of inadequacy, I have accustomed myself to speak of as the "imperial moods" of the manic-depressive psychosis, the royal attribute being given to them because of their very important office of selecting and furthering each one its own specific affective reactions. It is with the discussion of these "imperial moods" of the psychosis that we shall be concerned in the following pages.

Any observer of the affective life of the manic-depressive

patient during a period when he occupies the second level of profundity of disintegration, has noticed, as I have already repeatedly stated, that there are different constellations of tantrum impulses in the different phases of the psychosis. In the manic phase we find frequently a constellation consisting of supreme assertiveness, pugnacity, sex-urge, and food-seeking urge, while, in the depressed phase, we usually find a constellation of supreme fear or apprehension, negative self-feeling, retrospective remorse, and food-repulsion. The psychiatrist would not hesitate to refer this prevalence of the two constellations to the general moods of the two phases of the disorder; the moods that he terms elation in the manic and depression in the melancholic patient. These general moods are exactly the ones which I prefer to call respectively the feeling of omnipotency and the feeling of inadequacy. My preference in this respect is determined by the consideration that the terms elation and depression, properly understood, merely indicate the affective quality of the instincts of assertion and submission. Prof. McDougall, who has established such usage of these terms, maintains that the manic-depressive disorder consists essentially in the upset of the proper balance between the two tendencies of the sentiment of self-regard, the manic phase corresponding to the undue dominance of the self-assertive instinctive impulse and the depressed phase to the undue dominance of the self-submissive instinctive impulse (Bib. ref. 7, pp. 352-369). This view I have criticised in my paper on the manic-depressive disorder of 1926 (Bib. ref. 2). I have pointed out that, not only does a certain degree of assertiveness frequently come to expression in the depressed patient, especially in his insistive claim of being always on the peak of evil, but also that the affective life of the manic and the depressed moods is not as simple as Prof. McDougall suggests. Quite contrarily, a supremacy of several distinct, instinctive impulses form the characteristic constellations which we have just discussed. Such state of affairs makes it desirable to avoid, in the denomination of the selective moods of the psychosis, a terminology which may

suggest a higher simplicity than the clinical evidence bears out.[1]

It is when we come to the explanation of these moods of omnipotency and inadequacy that we confront the most difficult problem of the manic-depressive disorder. These moods are of paramount importance in the disease, and yet, how can we understand their evocation? It is known that extreme fatigue may produce in certain individuals a subjective feeling of general well-being and vital potency, in other words, that the subjective and the objective criterion of fatigue, the latter being decrease in efficiency, do not necessarily harmonize, profound fatigue being able to bring about a feeling of lightness of effort. In other instances, on the other hand, as may seem more natural, the fatigue expresses itself in a feeling of inadequacy, of real tiredness, of difficulty of effort. It is this dual and opposite subjective effect both of the fatigue and of the condition underlying the manic-depressive psychosis that makes the question of the moods so incomprehensible. How can the assumably identical disease process produce, in one person, the subjective feeling of omnipotency, in the other the subjective feeling of inadequacy, and how can it, in one and the same person during one phase of the disorder, produce the subjective feeling of omnipotency, during the other phase, the subjective feeling of inadequacy? It cannot be merely by virtue of different degrees of depth of disease condition. In such instance the onset and the progress of the disorder would always pass through the two phases in the same sequential order, which is not the case.[2] The variable

[1] While Prof. McDougall's theory is correct in that it explains the manic-depressive disorder by an upset of emotional balance, it is too narrow in ascribing this upset merely to an imbalance of the emotional components of the self-regarding sentiment. However, his theory may be said to be incorporated in the broader hypothesis I have here propounded.

[2] As an explanation of this most difficult problem, Prof. McDougall has suggested to me, in conversation, that perhaps both the fatigue-toxin and its anti-toxin are involved in the production of the manic-depressive disorder, and that prevalence of the former accounts for the depressive, prevalence of the latter for the manic reaction. (Compare also William McDougall and May Smith, "The Effects of Alcohol and some other

onset also excludes the purely psychological explanation of the manic reaction as a flight from reality and from the pain of depression. Such theory would presume that the disorder started invariably with an inadequate phase. We are here at a deadlock from which we cannot proceed, except by an entirely different route.

It has been suggested by various writers that the inclination to experience prolonged moods, such as the general feeling of increased potency and the general feeling of inadequacy, is determined by a constitutional agent, namely, the cycloid trait. The cyclothymic individual, according to this view, is one who, during normal healthy life, possesses such inclination to swing continually between prolonged moods, although the subjective reflection of these is only vague and far different from the exalted mood experience of the psychotic patient. If this is true, it leaves us a possibility to explain why the psychosis of one individual begins with a manic, of the other with a depressed phase. This would be a pure chance matter and referable merely to the quality of the mood in which the beginning disintegrative process happens to set in. If it sets in during a wave of feeling of increased potency, it would carry the patient into the manic phase of the disorder; if it sets in during a wave of feeling of inadequacy, it would carry him into the depressed phase of the disorder. In other words, the disintegrative process always sustains and intensifies the mood which is present at the onset of disorder, as a result of the cycloid tendency. The intensification of this mood would be explained by the vicious circle set up during the beginning disintegration by the release of the egotistic personality-part. The latter release would tend to bring fuel continually in support of the mood that is present at the onset. But such speculation, although it has led us ahead in some respect, in another respect merely projects our problem on a different

Drugs during Normal and Fatigued Conditions,'' Privy Council, Medical Research Council, London, His Majesty's Stationary Office, 1920, p. 29.) This seems to me a very interesting hypothesis, well worth considering as an alternative of the one put forth in this monograph.

plane. Our question is now: What is the nature of the cycloid temperament?

In an obscure and indefinite way many psychologists have felt that moods are related, at least partly, to vasomotor function. In view of the rather meager definite evidence in such direction, a more distinct hypothesis concerning such interrelation can be little more than a speculation. We can, however, outline on theoretical ground the peculiarity of a man's vasomotorium that would make him a cyclothyme, assuming that certain general pre-suppositions hold true. Such outline would mean an interpretation from psychology into physiology, and may be overthrown or substantiated by physiological investigation. I give it here for what it might be worth.

We may assume that, during purely vegetative normal life, our vasomotorium as a neuro-muscular and physiological unit maintains a certain state of balance, adjusted in such way as to allow a distribution of blood to the various organs of the body which is adequate to the purely vegetative functions and which presents only minor rhythmical changes in harmony with the rhythm of the latter. We may also assume that, whenever specific excitations occur such as the emotional, requiring a differently distributed function of the different bodily organs as compared with the purely vegetative state, the vasomotorium is an instrument so tuned as to favor purposefully abundant flow of blood to the organs particularly involved in the emotional conduct. This characteristic of the system to change the state of vegetative balance on excitation, according to need, we may conveniently speak of as its plastic propensity, just as we may say that a piece of wet clay changes its form on impact because of its plasticity. Furthermore we may assume that, after the emotional excitation has ceased and the emotional impulse has abated, there is a return to the vegetative vasomotor balance state, by virtue of the nature of the system itself. This propensity of the system to return to a vital equilibrium on the termination of upsetting excitation, we may call conveniently the elasticity of the system; but here the piece of clay does not furnish the adequate simile any

longer, because the clay, although possessing plasticity, is devoid of elasticity. A piece of soft rubber, on the other hand, would illustrate both characteristics, being capable both of changing shape on impact and of returning to its original shape on withdrawal of impact. The reader should clearly understand that the two concepts of plasticity and elasticity are used here to indicate independently working principles; the former being merely the propensity to change on excitation, the latter the propensity to change back on discontinuation of excitation. With this in view we may theoretically conceive of a peculiar defect of the vasomotorium, consisting in an irreciprocal efficacy-relation between the plastic and the elastic functions. Such defect we may denominate as hyperplasticity or as hypo-elasticity, or perhaps preferably as hyperplasticity-hypoelasticity, according to choice. The expression of this hypothetical defect would be that the change of balance of the system, by virtue of its plasticity, is not efficiently counterbalanced by the principle of elasticity, so that the system, after balance-upsetting excitation, is left for an unduly prolonged period of time with the imprint of the latter upon it. It becomes in other words, fixated in the form produced by its plastic principle. Now, if we assume that one component of the emotional quality that colors our impulse life is derived from a sensory stream set up by this change in balance of our vasomotorium, giving rise to vague organic sensations, we would obtain, in the individual of hyperplastic-hypoelastic vasomotorium, an outlasting of this component of emotional quality after the emotional excitation has abated, just because of the insufficient elasticity of the system in counterbalancing the plastic change. Such persevering of this one component of emotional quality may be exactly the mood. If there is any validity in this speculation we would have an explanation, in a general way, of the cycloid temperament. The cycloid temperament would be explained by the hyperplasticity-hypoelasticity of the individual's vasomotorium.

The specific nature of the moods of the cyclothyme being, on the one hand, a general feeling of increased potency, on

the other, a general feeling of inadequacy, may be explained from another consideration. It is fairly reasonable to think that a state of the vasomotorium which promotes abundant flow of blood to the skeletal musculature may produce a subjective feeling of ease of effort, of lightness, of potency; while the opposite state of the vasomotorium, checking flow of blood to the skeletal muscles, may produce the contrary subjective effect, notably, a general feeling of difficulty of effort, of paralysis, of inadequacy. Furthermore it is known, I believe, that certain emotional excitations, requiring for their goal-attainment, intensive involvement of muscular exertion, are accompanied by a purposeful adjustment of the vasomotorium in the direction to furnish the skeletal musculature with abundant blood-supply. Such is the case, I believe, when the pugnacity instinct is evoked and probably also when the assertive instinct and many others are excited. On the other hand, there exist probably other emotional excitations in which the opposite vasomotor effect is manifested. The shrinking of fear or of submission indicates probably the opposite change in the vasomotorium, a change by which blood is withdrawn from the skeletal muscles. It is fairly probable that quite a number of the emotional excitations fall definitely in one or the other of the two groups mentioned, the one which involves the allowance of increased blood-supply to the skeletal muscles and the one involving withdrawal of blood-supply from these. Adopting an old term in psychology, we may call these different emotions the sthenic and the asthenic affects respectively.

Let us now assume that a certain number of affects, A, B, and C, belong to the sthenic group, and another, D, E, and F, belong to the asthenic group. Let us assume, furthermore, that an individual with a hyperplastic-hypoelastic vasomotorium is thrown by an adequate situation into the emotional state A. Due to the inertia of the plasticity of his vasomotorium, or, if we prefer, due to the inefficiency of its elasticity, such an individual will experience, long after the emotional excitation has abated, the subjective sensory effect of the fixation of his vasomotorium. As the fixation promotes con-

tinually the abundant blood-supply to the skeletal muscles, he will suffer subjectively a feeling of ease of effort, a feeling of lightness or of increased potency. Suppose that, during this mood, an emotion of the asthenic group, let us say D, is adequately evoked. This will tend to throw the vasomotorium over into an opposite state as compared with the one maintaining the mood, but here a very intense excitation is needed in order to change the mood, because the vasomotorium is already fixated on the contrary side of the vital medium. On the other hand, every later evocation of a sthenic affect, such as B, or C, will maintain and somewhat exaggerate the mood, inforcing upon the vasomotorium a further change in the same direction in which, by its plastic principle, it is already fixated. This explains to some extent how, after the instigation of the mood, there are more chances of its maintenance and increase than of its breaking down and disappearance. Exactly the same thing would be true, in a general way, if the vasomotorium were fixated in the mood of the asthenic affects, D, E, or F. Here the fixation of the vasomotorium would result in the persevering of a general feeling of difficulty of effort, because of the continual shutting off of blood-supply to the skeletal muscles.

There is one more feature of the cycloid temperament that has not yet been taken up, namely, its very nature of being a cyclic inclination. I mean by this its nature of predisposing prolonged, continual swings between opposites of mood, between feeling of increased potency on one hand, and feeling of inadequacy on the other. Here also no interpretation is more than a speculation.

It is known that the smooth muscles which control the size of our small blood vessels are not subject easily to fatigue. This, however, does not mean necessarily that prolonged activity, such as is involved in the maintenance of the condition underlying a mood, may not finally result in fatigue. If this is true the vasomotor mood fixation would finally be brought to release by a gradually and slowly accumulating fatigue. A relaxation of the specific effector group which maintains it

would occur and this would tend slowly to reëstablish the vital balance of the vegetative state. When the latter is brought back, there will be a period of time when the evocation of the emotions of the group, corresponding to the just abated mood, will be prevented from imprinting vasomotor fixation by the still unrestituted fatigue of its adequate vasomotor effectors. During this period, only a fixation of a mood by the opposite emotional group will allow itself. The plastic principle is exhausted in one direction by the prolonged mood and can work for some time only in the opposite. This would account for the liability of opposite mood fixation, if conditions favor the excitement of opposite emotions, at the same time as it accounts for the abating of one mood after a long period of time.

If my theory concerning the cycloid temperament is valid, we may understand easily how the disintegrative process of the manic-depressive psychosis, in its onset, may find the individual by mere chance in either one or the other of the mood swings, and how, in the way I have previously indicated, it may accentuate it.

The psychological significance that these general and, according to my hypothesis, physiologically determined moods may attain when they become objects of uncritical rationalization, is a secondary effect. It is by such rationalization that they produce a number of these disproportional ideas of the self that are characteristic of the psychosis.

The selective activity of the mood on our thinking is an undeniable matter of common everyday experience, and needs hardly any comment. It is a well-known psychological law that acute emotional states determine attention, both in the realm of perceptual and imaginative thinking. This means that, during the acute emotional state, only such impressions or such associations attain meaning and thus become objects of thinking which harmonize with the trend of conation of the emotional condition. The same principle undoubtedly holds true for the moods or the general feelings. These also determine attention in such way as to favour thinking which, in a

general way, conforms with and supports the mood. In this manner, the mood will select those impressions which evoke emotions of its group; in other words, a general feeling of increased potency will select for perceptual or imaginative thinking only such objects as evoke the sthenic affects, while a general feeling of inadequacy will select with preference such objects as evoke the asthenic affects. We can easily see that such state of affairs will accentuate immensely the vicious circle of the mood condition.

The above description of selection gives its cognitive aspect, The fact, however, that the selection takes place by means of allowing and preventing impressions and associations to attain meaning, suggests that it is ultimately a selection of impulses, the latter being the determinants of meaning. I have already pointed out how the theory of vasomotor fixation may account in a general way for the conative aspect of selection.

It is very important for the understanding of the various reaction forms of the manic-depressive psychosis to recognize clearly this selective activity of the mood. It is such selection that accounts for the two different affect constellations that we can distinguish definitely in the manic and the depressed patient on the first and second level of profundity of disintegration. The mood in itself cannot be explained by the disintegrative process merely. The theory of the constitutional cycloid type, which I have elaborated upon above, may give some explanation of it, even if not perhaps a fully conclusive one.

There is a picture of depression which I am anxious to call to attention because it is seen rather frequently. It is a picture in which none of the symptoms which are directly referable to the disintegrative process are overtly manifested. Consequently it is difficult to place it on any one of the three levels of profundity of distintegration. I refer to the plain retardation with depression. There are two variants of such retardation that can be distinctly observed.

The first variant is characterized by the fact that the retardation seems to affect only conscious, volitional activity. A

patient suffering from it may carry on the automatic and semi-automatic acts with normal accuracy and speed. For instance, he may walk with normal pace. A fly settles on his hand; he may immediately and efficiently wipe it off. He may use his handkerchief properly and proficiently. He may wash himself like a normal using the towel like a normal. A woman patient may carry on such automatic occupations as knitting, approximately as well as a normal person, or another patient may turn the leaves of a magazine just in the same way as anybody. On the other hand, if you ask the patient a question, he seems to be unable to respond properly. You may notice for a while signs of attempt to respond on the side of the patient, but the effort of the attempt soon abates and with a sigh of resignation or an apologetic smile or shrug of the shoulders he will soon fall back into a kind of hopeless attitude of "what is the use, I can't anyhow." Occasionally, though rarely, the initial effort breaks through and you get a response to your question. This response is practically always relevant and comes out with normal or perhaps a little exaggerated speed, somewhat explosively. As another test of the condition you may ask the patient to write his name on a piece of paper. There will be a tremendous initial difficulty in doing it and, mostly, nothing will result. However, on rare occasions, the initial difficulty is overcome and the patient will write his name. On such occasions his writing is rapid, explosive, and of good texture. Or you may ask the patient to move from one chair to another; the same tremendous difficulty in initiating the activity according to your command will again be seen. As a rule the patient will not be able to do as you urge him. If, however, he succeeds in breaking through, the movement, the walking, once begun, will be of normal rapidity. The term initial retardation can to my mind be applied very properly to the condition described, initial retardation of conscious volitional effort.

The second variant of retardation differs from the first in essential respects. Here the retardation does not seem to be limited merely to conscious volitional activities, but it also

stretches to the automatic and semi-automatic ones. The patient walks slowly; such acts as wiping away a fly, washing, using the handkerchief, and so forth, are either absent or slow and fumbling. A woman patient suffering from this form of retardation is incapable of knitting. If you ask a question, there will be mostly no response. In rare instances a response may follow after long delay, even after minutes. When it comes, it is as a rule adequate, but it is not delivered with explosive rapidness as was the case in the former form of retardation. It is slow and, oftentimes, it may be carried only to partial completion. In the same way, you may ask a patient to execute a certain act, for instance, to take your pencil, walk across the room, and put it on the mantelpiece. After a long delay the patient may start off. He fumbles for your pencil; slowly and with extreme difficulty of effort he rises and drags himself across the room to the mantelpiece where he places the pencil. The interesting point is that the act is carried out adequately although slowly and with delay. The retardation is more than an initial one; it is evenly divided over the whole course of the activity. If you ask the same patient to write his name, he may begin hesitatingly; he will write very slowly and with a feeble line and, before he has completed his signature, his effort may have gradually faded off and the second half of his name may be merely a hardly perceptible shapeless line. We may conveniently call the second form of retardation just described "homogeneous retardation" to distinguish it from the first form, or the "initial retardation."

In view of the fact that, in both the forms of retardation, the response of a patient is as a rule adequate whenever it can be obtained under strong urging, I feel that the purely receptive understanding of simple facts is not essentially impaired in the retarded condition. Whether or not the elaboration of facts is impaired is difficult to demonstrate definitely, but I feel convinced that such impairment is the case. The two forms of retardation differ most strikingly in that the first form involves only conscious volitional effort, not

automatic or semi-automatic activity, and is essentially an initial retardation, while the latter form involves also the automatic and semi-automatic conduct and is equally distributed over the total course of any activity.

The clinical differentiation of the two forms of retardation is easy, but the interpretation of them is rather difficult.

The fact that the first form of retardation leaves undisturbed the automatic and semi-automatic activities, impairing only conscious volitional effort, suggests that it is more predominantly psychological than the second form. At the present stage of my observations I am inclined to explain such retardation by directly referring it to the accentuated feeling of inadequacy. I believe that it is based on a psychological intensification of this feeling, an intensification which is profound enough to have established a paramount negative belief in capacity to do, act, and decide. Such belief, in accordance with a principle which is observable in less extreme form within the realm of the normal, may extensively paralyze volitional effort. We may say, in other words, that, in this form of retardation, the mood of inadequacy in itself has attained tantrum supremacy and, as a secondary effect, produces by rationalization a still further reinforcement of itself by nourishing an unshakable belief in the patient that he is incapable of acting. This belief will naturally paralyze volitional effort but leave automatic and semi-automatic activities undisturbed. If such interpretation is true, we would have to place the condition of this form of retardation on the second level of profundity of disintegration. It represents, in a way, a state of tantrum liability, even if neither of the two tantrum constellations, which we have observed previously on this level of disintegration, come to expression, but merely the supremacy of the inadequate mood.

The second form of retardation involving also the automatic and the semi-automatic activities, represents, as I see it at present, merely a complication of the state of affairs of the first form by an extensive, real exhaustion of the psychomotor effector system of the body. Consequently, in this

second form, we have what we may call the objectively unjustified intensification of inadequacy by the disintegrated condition, conjoined with an objectively justified inadequacy determined by exhaustion; while, in the former form, we have merely the objectively unjustified intensification of inadequacy by the disintegrated state. The above interpretation of the two kinds of retardation is only tentative, but it is the only one that I can offer on the basis of my present observations.

It is, especially, the picture of retardation which has led certain psychiatrists to feel that disorder of thinking is the fundamental impairment in the manic-depressive psychosis. Such is of course not the case. As a general psychological proposition, there is no functional thinking disorder per se. Any functional disorder is conative-cognitive at the time, and the fact that the cognitive reflection of the aberration sometimes may be more strikingly manifested than the conative in the clinical picture of the disease, should not make us blind to the recognition that this reflection is merely one side of the functional disturbance. I have just suggested that, in the case of the retarded patient, there is probably a paralysis of volitional effort maintained by a strongly established negative belief in the capacity to act, which in its turn is rooted in the general feeling of inadequacy that results directly from the physiological condition of the mood. This negative belief assumably reinforces, in such cases, the feeling of difficulty of effort that is directly produced by the sensory stream from the patient's mood-fixated vasomotorium. The apparent thinking difficulty of the retarded patient is thus a conative-cognitive disorder.

As a general support for the proposition that no functional disorder is cognitive merely, but always conative-cognitive, we may compare the "thinking difficulty" of the retarded patient with other "thinking disorders" of the manic-depressive psychosis, such as are manifested in other conditions of the disease, notably, when the patient presents definitely the picture of the second and third level of profundity of disintegration. A patient on the second level suffers most de-

cidedly from a thinking disorder; his judgment is severely impaired and he maintains obvious delusions, but here the thinking defect is without doubt determined by another abnormality of striving, more especially, by the uninhibited supremacy of his impulse life, which evades any checking and critical control by a higher, purposeful, integrative agent.

On the third level of profundity of disintegration the patient, no doubt, presents a thinking disorder. But here again the thinking disorder is merely one reflection of the general disorder condition. The conative side of the disorder is, in this case, the continual chaotic conflict between numerous non-integrated impulses, which prevents the maintenance of sustained one-directed effort for a sufficiently long period of time so as to result in a purposive trend of thought, or in an adequate verbal response to a simple question.

Whether or not, in organic mental disorder with a definite localized structural leasion of the brain, we may obtain a disorder that can be called properly a purely cognitive one, is a question which I am not prepared to answer here.

It remains to consider the third of the "imperial moods" of the manic-depressive disorder, the feeling of unreality. The propensity of our immediate environment of appearing subjectively real to us, is a matter of the meaning of its objects and is determined by our striving relative to the latter. The cipher of the general principle by which the world seems real to us, its occupants, is briefly this. Life, its objects, and deeds, become real and a personal adventure as we strive and as, in striving, we face and overcome thwartings and obstacles. If, for some or other reason, our general urge should abate, then life would change its meaning, it would lose its feeling of personal reference, it would seem different and unreal. There are certain individuals who are born with an undue weakness of urge, to whom life never acquires strongly the propensity of realness. Those, like Goncharov's hero Oblomov, are the victims of continual ennui; they always feel bored, and strangely alone and outside. Their own selves do not even seem real to them. But the feeling of unreality occurs not

only when urge in general abates, it also occurs when urge changes direction. Things will seem to us as they should be as long as we strive in reference to them in the way we are accustomed. If suddenly we should begin to strive differently towards them, they would change, they would seem different, unfamiliar, and unreal. And so would we appear to ourselves. "Suppose," writes McDougall, "that you woke up one morning, with all your conative trends and settings completely transformed or redirected, hating all those you had loved, disliking all things you had liked, caring nothing for money or reputation, turning your other cheek to the smiter, and loving those that despitefully used you, angry and scornful where you had been tender, pitiful, and sympathetic. Then, indeed, you would feel yourself to be another man . . ." (Bib. ref. 6, p. 371). A large measure of the unrealness which attaches to our early memories is undoubtedly due to such change of striving, a change, in general, from childhood conative attitudes into adult ones.

This principle accounts for the feeling of unreality from which the manic-depressive patient suffers and which he can record in retrospection after recovery. It is felt most strongly on the third level of profundity of disintegration, but it is not uncommon also on the second. The adaptively integrated urge which is characteristic of normal health is modified temporarily, in the psychosis, into a chaotic disintegrated one, consisting of a vast multitude of uncontrolled impulses which sometimes express themselves with supreme intensity in tantrums, sometimes conflict and interfere with each other in a purposeless, chaotic manner. This is a change of urge of immense profundity and well sufficient to produce a feeling of unreality. There is no doubt to my mind that this third "imperial mood" of the psychosis is adequately explained by this principle, and that, consequently, the general feeling of unreality can be directly referred to the disintegrative process, while the other two "imperial moods," the feeling of omnipotency and the feeling of inadequacy, cannot.

The feeling of unreality, just as the feeling of omnipotency

and the feeling of inadequacy, is important in the psychosis for the reason that it determines very specific conduct-forms or symptoms, especially on the third level of profundity of disintegration. It furnishes, in fact, the background for the occurrence of a number of these symptoms which are spoken of by the psychiatrist as indicators of confusion, in the broad psychiatric sense of the latter term. What I refer to specifically are such conduct-forms as the outer or objective distractibility, the mistaking of the identity of people and of the meaning of objects, and the symptom denominated as resistiveness, all of which are characteristic of the third level of profundity of disintegration.

The psychology of outer distractibility and of resistiveness I have dealt with in my recent article on confusion and I follow here closely my earlier discussion of this problem (Bib. ref. 3).

The chaotic state of continual interference of one impulse by another simultaneously active one, which is characteristic of the third level of profundity of disintegration, is undoubtedly enough to account for a considerable part of the distractibility of the patient, notably for what we may call the "inner distractibility." But the distractibility to which the psychiatric term more especially refers, namely, the liability to be distracted by any outer occurrence even of trivial kind, may require a further principle for its interpretation. It is to the promotion of such "outer or objective distractibility" that I think the general feeling of unreality contributes. On the background of this feeling, naturally any impressions from the outside are liable to appear in some measure strange to the patient, and attaining such attribute of strangeness, they are liable to evoke his curiosity instinct. In addition to the "inner distractibility" due to continually conflicting simultaneous impulses, we may thus recognize an "outer distractibility" due to the peculiar liability for the curiosity instinct to be activated by the multitude of impressions received through the sense organs, latter liability being an expression of the underlying general feeling of unreality.

Curiosity is peculiarly liable to blend with fear. Any observer of curiosity in animals will be struck by the fact that the animal in front of a strange object seems to sway between two impulses, one to approach it so as to obtain fuller perception of it, the other to run away from it in fear. The predominance of one or the other of these impulses is probably determined to some extent by the degree of strangeness of the object, but, above all, by any indication of aggressive behaviour of the latter, when the impulse to flight immediately conquers the impulse of curiosity. This principle explains, I believe, the symptoms of resistiveness in our patients on the third level of profundity of disintegration. The term resistiveness has come to apply to a very specific kind of clinically observed conduct. Whenever you try to manipulate any limb of the deeply disintegrated patient, he will withdraw his limb or resist your manipulation as if afraid. This kind of conduct is most frequently seen in patients approaching the depressive stupor, when, as has been pointed out previously, overt conduct has abated considerably by virtue of an extensive exhaustion of the psycho-motor effector system. There is little doubt that this resistiveness is a true fear-reaction which is entirely different in its psychological motivation from the negativism oftentimes showed by the stuporous schizophrenic. The feeling of unreality which is the background for the symptom makes all objects seem strange and uncanny. The manipulation by the physician of the patient's limb has just enough of aggressiveness to turn the uncanny object into the definitely fearful. In certain instances the resistiveness may take on a more generalized form. The patient who, before you enter his room, may have displayed some sway of activity indicating a certain measure of sequential response to disparate conflicting impulses, on your approach may suddenly shrink and become rigid. He may even hold his breath. This reaction I refer to as a generalized resistiveness because I believe it to be the manifestation of the typical sham-death response to fear, and has the same motivation psychologically as the resistiveness. I suggest that

the clinician keep in mind that this state of sham-death is vaguely different from the plain depressive stupor, latter being merely the expression of the exhaustion of the psychomotor effector system. For the sake of the subtle analysis of the patient's condition it is profitable to keep them apart. There is enough clinical difference between the two to allow a discrimination on close observation.

The symptom spoken of as "Personenverkennung," or mistaking the identity of people, is merely a subdivision of a broader tendency that we may call "the tendency to misinterpret the meaning of objects." It would seem to be essentially a joint type of "outer" and "inner distractibility" by which one or other trait of the mis-identified person distracts the patient's mind to some absent individual by superficial association, a distraction that lasts long enough to allow a verbal expression, for instance, such as the following: "You are President Wilson," or "you are the attorney of my mother-in-law." The kinship of "Personenverkennung" with the broader tendency to mistake the meaning of objects may be illustrated by a woman patient who, on the physician's visit, suddenly pointed at the wall and exclaimed: "Look at this beautiful vase." Later, during recovery, she was able to retrospect on the incident, and pointing at a crack in the wall she explained that it had the curvature of a vase and that it was the object which had made her think and speak of such. The crack might just as well have called to her mind the nose of M. Cyrano, and then she would have claimed the presence of this gentleman or at least the presence of his portrait on the wall. In such case we would have had a misidentification of an object with a person. All such misinterpretations, characteristic of the third level of profundity of disintegration, have probably the same basis. Trivial sensory impressions distract the patient and call forth superficial associations which are momentarily accepted without critical checking, leading to a vague "apperception" of a false object. Conditioning the whole procedure is the complete disintegration of purposively adaptive sustained urge.

I doubt that the objects thus "mis-apperceived" are accepted with profound conviction as real. On the second level of profundity of disintegration, misinterpretation of objects may also occur, but here false meaning of these may be accepted with lasting conviction, the misinterpretation being determined by a sustained tantrum impulse.

On the border between the second and the third level of profundity of disintegration we see sometimes another interesting conduct form which, according to the retrospective account I have obtained from one young girl patient, was superimposed, in her case, on the feeling of unreality. This young girl showed the symptoms of the second level by a liability for tantrum fears. Betweentimes she was mostly wandering about aimlessly in a manner that suggested the indefinite sway of activity characteristic of disintegration to the third level of profundity. At such times she was also apparently somewhat dazed, the general vital intensity being low. On my visiting her, it happened several times that she eagerly clung to me as if in distress and as if to seek shelter. Furthermore, while doing this she searchingly manipulated my arms, head, hands, clothes, etc., looking closely at me. Her motive for this, as she told me later was to assure herself of the realness of my person. The whole world seemed dream-like, unsubstantial, and it was a relief to her to sense things and explicitly experience their resistance towards her manipulations. Exactly the same kind of conduct I have observed in quite a number of patients in the same condition as the girl referred to above, but only in her case have I been able to obtain an explanatory retrospective account of the motive behind it. In order to get a name for this form of symptomatic conduct, I suggest that we denominate it "manipulation folly."

There are probably a number of other peculiarities of behaviour of the patients on the third level of profundity of disintegration which may have their direct explanation as reactions to the general feeling of unreality, and which are well worthwhile for clinical observation.

CHAPTER V

A Diagrammatic Summary of the Principles and Symptoms of the Manic-Depressive Psychosis

The interaction of principles in the production of the symptomatic reactions of the manic-depressive psychosis is very complex. I have tried to describe it in this paper as my observations have led me to understand it. As a further clarification of the matter I shall submit a diagram which will serve, also, as a summary of my total previous discussion. In this diagram I shall endeavour to mark off and group the symptoms in such a way as to express what is fundamental in the disorder and what is accessory, what is determined by something else and what is the determinant.

There are three fundamental agents responsible for the manic-depressive psychosis. These are given in the diagram under (A), (B), and (C). Two of these, (A) and (B), are constitutional determinants of the disorder, the third, (C), is acute and contracted (Fig. 3).

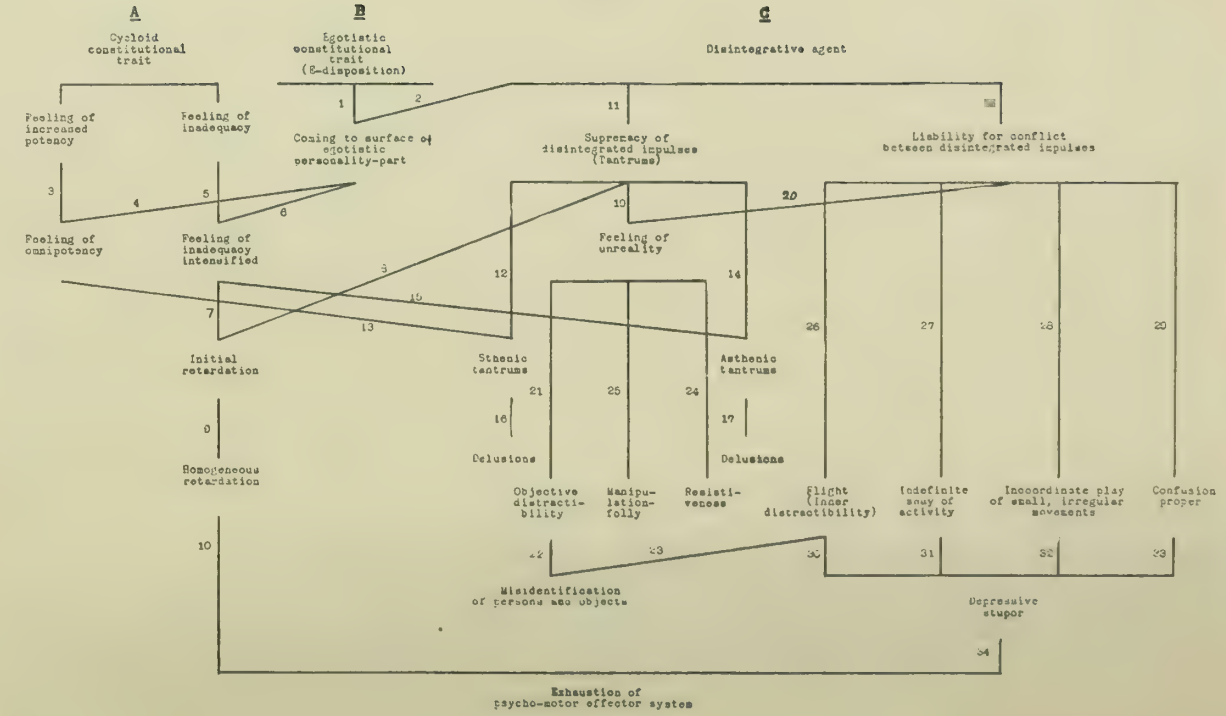
(A) is the cycloid constitutional temperament which makes the patient liable to suffer, even during normal healthy condition, prolonged swings of mood, from a feeling of increased potency, on the one hand, to a feeling of inadequacy, on the other.

(B) is the constitutional egotistic trait, or the E-disposition. This accounts for the establishment by repression of the subconscious egotistic personality-part which we have reason to believe exists in the majority of the individuals who, under general disintegration, break down into manic-depressive disease.

(C) is a disintegrative agent which produces the general falling down of the effects of adaptive integration and brings about the state to which is referable the majority of the symptoms of the disease.

The first effect of the beginning disintegration is to break down the less profoundly built inhibitions, namely, the ones

Figure 3


A
Cycloid constitutional trait
B
Egotistic constitutional trait (E-disposition)
C
Disintegrative agent
Feeling of increased potency
Feeling of inadequacy
Coming to surface of egotistic personality-part
Supremacy of disintegrated impulses (Tantrums)
Liability for conflict between disintegrated impulses
Feeling of omnipotency
Feeling of inadequacy intensified
Feeling of unreality
Initial retardation
Sthenic tantrums
Asthenic tantrums
Homogeneous retardation
Delusions
Delusions
Objective distractibility
Manipulation-folly
Resistiveness
Flight (under distractibility)
Indefinite sway of activity
Incoordinate play of small, irregular movements
Confusion proper
Misidentification of persons and objects
Depressive stupor
Exhaustion of psycho-motor effector system

maintaining the repression of the subconscious egotistic personality-part. This expresses itself in the coming to the surface of egotism in the onset of the psychosis. The egotism has a double origin; it is partly determined by the E-disposition, partly by the beginning disintegration, a state of affairs which is indicated in the diagram by the two routes (1) and (2), both converging to the point which diagrammatically represents the symptom in question.

Independent of the mood in which the beginning disintegration sets in, whether in a swing of hyper-potent feeling or in a swing of feeling of inadequacy, the mood which by chance is predominant at the onset becomes fixated and intensified by the predominantly egotistic urge. This takes place by virtue of the unduly egocentric direction of the interests of the egotist. A vicious circle is created which produces, on the one hand, an extreme feeling of omnipotency, on the other, an extreme feeling of inadequacy. These two conditions again have a double origin, on the one side, in the cycloid temperament, and on the other, in the dominance of egotism, a situation that is indicated in the diagram by the routes (3) and (4), and (5) and (6).

The extreme feeling of inadequacy in some cases paralyzes volitional effort completely and results in the condition we have called initial retardation. Probably a more profound degree of disintegration than the one producing the symptoms of the onset stage is also involved in the initial retardation, assumably a disintegration to the second level of profundity. In the diagram the initial retardation is referred to the feeling of inadequacy and to the disintegration of the second level of profundity by routes (7) and (8).

The initial retardation may be complicated by an extensive exhaustion of the psycho-motor effector system of the body. This leads to what we have called "homogeneous retardation" (diagram, routes (9) and (10)).

The increasing disease results gradually in the disintegration to the second level of profundity which is characterized

by a liability for tantrums. This development is expressed in the diagram by route (11).

The liability for tantrum reactions brings out two definite constellations or groups, the sthenic and the asthenic. The determinant of these is one or the other of the two "imperial moods" of the psychosis, the feeling of omnipotency and the feeling of inadequacy. The former feeling favours the sthenic constellation, the latter the asthenic. This is in the diagram expressed on the one hand by route (12) and (13), on the other by route (14) and (15).

The sthenic and asthenic tantrum groups may secondarily determine grave judgment defects and delusions (diagram, route (16) and (17)).

The continually deepening disease finally brings the patient down to the third level of profundity of disintegration which is characterized by a continual liability for chaotic conflict between non-integrated disparate impulses (diagram, route (18)).

Both the inclination for tantrum reactions on the second level of profundity of disintegration, and the liability for conflict between disintegrated impulses on the third level, represent profound general modification of the normal mode of purposive striving. Thus, these liabilities, either each one separately, or both in conjunction, produce the third of the "imperial moods" of the psychosis, the feeling of unreality, a situation that is expressed in the diagram by the routes (19) and (20).

The feeling of unreality easily brings out a tendency of outer or objective distractibility. The mechanism is as follows: on the background of the general feeling of unreality, all impressions from the outside will seem to the patient strange and unusual. This will tend to evoke his curiosity instinct on any stimulation from the outside (diagram, route (21)). The inner distractibility of the same patient is merely another term for flight.

Inner and outer distractibility in conjunction may produce such symptoms as a tendency to misidentify people or to mis-

interpret the meaning of objects (diagram, routes (22) and (23)).

The feeling of unreality is also liable to bring out the symptom of resistiveness. Resistiveness is a fear reaction, and on the background of the general feeling of unreality, the strange stimulation, particularly if it is of aggressive nature, will evoke, instead of the curiosity impulse, the fear impulse which manifests itself in the symptom (diagram, route (24)).

The feeling of unreality finally may produce the symptom I have spoken of as "manipulation folly" (diagram, route (25)).

The liability for continual conflict on the third level of profundity of disintegration has, in itself, four direct symptom expressions, flight of ideas and of directed conduct (inner distractibility), indefinite sway of activity (contentless restlessness), incoördinate play of small, irregular movements, and confusion proper (diagram, routes (26-29)). The first three of these symptoms represent sequential reaction to disparate, simultaneously active, disintegrated impulses. They differ essentially in this respect that there is a decrease in the amplitude of each consecutive response from flight to the incoördinate play of small, irregular movements. Confusion proper, which is never more than a momentary condition, is identical with complete deadlock between disparate impulses, and its expression is complete immobility.

The continual sequential reaction to the disparate conflicting impulses on the third level of profundity of disintegration may gradually exhaust the psycho-motor effector system of the body, involved in the response. This brings about a general abating of conduct which may result in approximate immobility, the depressive stupor (diagram, routes (30-34)).

As a further guide to the diagram I submit below an alphabetical list of all the symptoms of the manic-depressive disorder. Within parentheses after each symptom is given the routes which in the diagram indicate its determinance.

Conflict, liability for (18).
"Confusion proper" (29).

Delusions (16-17).
Distractibility, inner (26).
Distractibility, objective (21).
Egotism, coming to the surface of (1-2).
Flight (26).
Inadequacy (intensified), feeling of (5-6).
"Manipulation folly" (25).
Misidentification of persons and objects (22-23).
Movements, incoördinate play of small, irregular (28).
Omnipotency, feeling of (3-4).
Retardation, homogeneous (9-10).
Retardation, initial (7-8).
Resistiveness (24).
Stupor, depressive (30-34).
Sway of activity, indefinite (27).
Tantrums, asthenic (14-15).
Tantrums, liability for (11).
Tantrums, sthenic (12-13).
Unreality, feeling of (19-20).

CHAPTER VI

General Theoretical Conclusions

I have built this thesis on two broad, general and, I believe, reasonable presumptions, namely, (1) that the integration of human mind into personality is concomitant, neurologically, to the intricate acquisition of integration of neurones and neurone-systems on the highest level of the nervous system, the cortical; (2) that the effect of the depressant drug on the nervous system is essentially to derange this cortical integration and thus produce a general disintegration of mind.

The theory concerning the manic-depressive psychosis, the defense of which my discourse was intended to evolve, is the following: The manic-depressive psychosis is due to a toxemia by a substance of the general nature of the depressant drug, which deranges in a general way the integration of the neurone systems on the cortical level (general dissociation of the cortex) and thus produces psychologically a general disintegration of personality. As the toxin responsible for this condition is not known and as the neural derangement cannot be seen under the microscope, the only evidence which can be brought into support of the theory would be a clear demonstration of the fact that all the symptoms, or at least the major symptoms of the disorder, can be properly interpreted as disintegrative, or as signifying, essentially, the temporary undoing of all the effects which the process of adaptive integration has built up in the psychogenic evolution of the individual.

As the analysis of the variety of manic-depressive disease symptoms, which I have undertaken here, points to the plausibility of such interpretation, my endeavour, even if it is not conclusive, brings fair support to the toxic theory of the manic-depressive psychosis.

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